2002

Essence of Cultural Competence: Listening to the Voices of Occupational Therapy Students

Roxie M. Black
Lesley University

THE ESSENCE OF CULTURAL COMPETENCE: LISTENING TO THE VOICES OF OCCUPATIONAL THERAPY STUDENTS

A DISSERTATION

submitted by

ROXIE M. BLACK

In partial fulfillment of the requirements
for the degree of
Doctor of Philosophy

LESLEY UNIVERSITY
September 10
2002

ABSTRACT

As the demographics of the United States change to include a more diverse population, occupational therapy practitioners will be faced with the challenge of working with clients and colleagues who are culturally different than themselves. It is imperative that practitioners develop the characteristics and skills necessary to provide culturally competent care.

The development of cultural competence must begin in occupational therapy educational programs, and educational outcomes must be assessed. This study examines the perceptions and meaning of cultural competence and culturally competent care as described by occupational therapy students in their final year of occupational therapy education. The purpose is to determine whether students who have received education that included diversity and multicultural content see themselves as developing cultural competence.

Using Moustakas' (1994) phenomenological methodology, I interviewed and analyzed the words of twelve students from two major Universities in the Boston area. Study participants were asked to describe their experiences with, and perceptions of, cultural competence and culturally competent care.

The study findings indicate that although these students recognize characteristics of cultural competence similar to those found in the literature, they also perceived that becoming culturally competent is a choice, a volitional act; that knowledge is important, and that personal experience with cross-cultural interactions provides the most transformational learning; and that feeling comfortable in cross-cultural situations is an important outcome. In contrast with the literature, the majority of the study participants did not identify cultural self-awareness as a characteristic of cultural competence.

Many implications for occupational therapy educators arise from these findings, including a need for increased faculty development, a need for teaching/learning strategies that facilitate cultural self-awareness and increased knowledge of sociopolitical realities, a need for cross-cultural experiential opportunities, and a need for continued research in diversity and cultural competence.

ACKNOWLEDGEMENTS

There are many people to thank for the support they have given me during this almost-seven-year process. First of all, I wish to thank the student participants of this study and the pilot study, who volunteered their time and graciously shared their thoughts, experiences, perceptions and stories. Without you, there would be no study.

I also want to thank the numerous students I have taught over a nineteen-year academic career and who have taught me in turn. I learn from each of you every semester, and I am so grateful to be in a position where I can be a co-learner with you. A special thank you to those of you who have read parts of my research and have encouraged me in this study.

To my doctoral committee, Claudia Christie, Diana Bailey, Judith Beth Cohen, and Mary Clare Powell, thank you so much for all the thoughtful questions, careful reading, and helpful feedback. The quality of this dissertation has been tremendously enhanced by your efforts. I truly appreciate your willingness to help me maintain the schedule for completion of this work. You were all great!

My family; Mom, Heather, Andy, Dan, and Bette, have not only been tremendously supportive, but extremely patient with my lack of time for them. They have often had more confidence than I have regarding my completion of this project and my success. I love you all and give you thanks and kisses. I promise to have more time for play now.

I also want to thank the three academic administrators at the University of Southern Maine; President Richard Pattenaude, Provost Joseph Wood, and Dean Betty Robinson, who have kept my feet to the fire, especially these past eighteen months. You have supported, pushed, cajoled, teased, goaded, and generally made nuisances of yourselves, but I recognize and appreciate that you have done this out of concern and support. I thank each of you for caring.

To my special friends; Glen, Linda, Nancy, and Ray, including my faculty colleagues at Lewiston-Auburn College, especially Lisa, Chris, Mary Anne, and

Nancy, I want to say thanks for listening to my continuous chatter and moaning, and for all your encouragement. Your friendships mean the world to me.

My canine and feline friends have also sustained me. Thanks to Beau for being generally patient but for reminding me when it was time to play, and to Maverick for his daily vigil on my desk as I studied. You guys were always the constant companions in my often quite solitary pursuits.

And finally, a very special thank you to the members of the doctoral writing group at Lesley University that I have been part of for the past four years. Suzanne Spreadbury, Mary Knight-McKenna , Susan Griffith, Sandras Barnes, Peggy Burke, and Amy Rutstein-Riley are very special women who have supported me in this process, lovingly and honestly critiqued my writing, encouraged me when I didn't think I had anything of substance to say, taught me how to be a better writer and a critique of writing, laughed and cried with me, and provided me not only with a community of learners, but a sisterhood of friends. Thank you all so much. I love each of you and could not have done this without you.

TABLE OF CONTENTS

CHAPTER 1

INTRODUCTION

Personal Justification for the Study

I am a White, middle class, occupational therapy educator who has been teaching White, middle class students in a predominantly White women's profession for the past eighteen years. More than a decade ago, as a result of my examination of feminist and critical theory as part of my master's degree work, I became aware of the changing demographics of this country and the oppression of non-dominant groups. I began to think about the meaning of this for me as an occupational therapy educator, and wondered about the meaning for occupational therapy students and practitioners. As a result, for several years now, I have studied, read about, planned courses and delivered content related to culture and diversity as part of an occupational therapy curriculum. Much of the course work in my doctoral program has been focused on issues of diversity. I have incorporated my new knowledge into the classes I teach in an attempt to increase students' awareness of diversity and culture and its implication for occupational therapy practice. This has been exciting work. I have learned a tremendous amount from the students I have taught, especially about myself as an educator.

Many of the undergraduate students I taught were the first in their family to attend college. The majority of them were White and held traditional world views . It was fulfilling to see them begin to question their values and beliefs and begin to look at the world in a more open and questioning manner. It felt good to hear them use more inclusive language and begin to develop effective communication skills. Although the graduate students I now teach have more experience in the world, many of them are also new to the ideas and concepts embedded in diversity education. I have been pleased to watch them apply these concepts to occupational therapy cases.

As my doctoral studies continued, my interest in diversity began to focus on the development of cultural competence which led me to coauthor a book with an African American woman on the subject (Wells & Black, 2000). This fascinating process required me to delve into the literature on the subject and helped me to reflect on compelling issues such as the social construction of Whiteness, power and privilege, and multicultural pedagogy. Additionally, my coauthor and I found ourselves negotiating and working through issues of race and privilege as we worked together to compete the book. For example, Shirley sometimes speaks and writes in a style known as *BlackEnglish.* It was difficult for me to approach her with this at first because I was aware of and sensitive to my privileged position. However, we did talk about it and she certainly agreed that I should edit any grammatical errors that I saw. During this discussion, we both referred to Lisa Delpit's (1995) work regarding the importance of giving every group of people the skills to be successful in the dominant society. I learned a tremendous amount during the three years of writing and book production, and realize that I now have even more questions than when I began this process. Some of these are listed below.

Because I have a vested interest in providing the best possible education for my students, I have often wondered about the impact of diversity content on the students who take my courses. How effective were my efforts? Even though course evaluations were often positive, and students often commented on how much they had learned, I began to wonder whether I was truly facilitating the development of cultural competence in the students I teach. I knew I was increasing content on diversity and culture, but was this actually moving students towards cultural competence? I've questioned how meaningful it is for a White teacher to teach about diversity to a White student population. How can I truly impact students' perceptions and understandings when I am part of the dominant sociocultural group and share that world view? Continued study in this area has led me to accept my place as a White teacher of diversity. Teaching about and reflecting on White privilege is now an emphasis in my courses. I believe that students construct their own knowledge based on their life experiences and social location. How, then, can I

be sure of what they are learning? Do they even understand what cultural competence means?

During this period of questioning and research, It came to me that students' voices were missing. They were often not included in the research studies I had examined during my literature review, nor had Shirley Wells and I included them in our book (Wells & Black, 2000). I began to wonder how students actually talk about and experience cultural competence. What does it mean to them? How do they describe a culturally competent person? Can they recognize culturally competent care? When they leave my classroom are they practicing culturally competent care? These are some of the questions that I bring to this research study.

Occupational Therapy and the Need for Culturally Competent Practitioners

Occupational therapy is a health and human service profession which identifies humans as occupational beings. Occupations are the meaningful activities in which people engage that determine and are determined by their roles and identity. Using a client-centered approach, occupational therapy practitioners assist people with impairments to improve their occupational performance. They do this by recognizing a client's values and interests and collaborating on an intervention approach. A person's values, beliefs and interests are determined by one's sociocultural background, as are the occupations or activities that are meaningful and in which one engages. One's cultural beliefs also determine how a person defines health and wellness, how she interprets and responds to the sick role, and how she interacts with health care personnel.

Although the changing demography of the United States has resulted in an increased number of ethnically diverse and immigrant healthcare clients, people who are homeless and needy, and folks who more openly proclaim their sexual orientations (U.S. Dept. of Health and Human Services, 1997), occupational therapy practitioners continue to be predominantly White, middle-class and heterosexual.

This uneven distribution assures that many occupational therapy practitioners will be working with clients who are culturally different than they are and may come from a different sociocultural background and position in our society. In order to be effective in working with people from diverse cultural backgrounds, occupational therapists must be not only sensitive to difference, but also skilled in interacting with all people. They must be sensitive to their White privilege and competent in dealing with people from cultural backgrounds different from their own. In other words, they must be culturally competent. At a time in United States' history when there is more diversity in our population than ever before, with predicted significant growth of non-dominant groups over the next twenty years (US Dept. of Health and Human Services, 1994), providing culturally competent health care is vital. Thus, there is a significant need for a study of this kind.

Cultural Competence in Research and Education

Cultural competence is a term that is seen more and more frequently in the fields of nursing, social work, and counseling psychology (see chapter 2), and is gaining precedence in other healthcare fields, including occupational therapy. Over the past decade, a limited number of practice and research articles on cultural competence have appeared in occupational therapy journals (Dillard, Andonian, Flores, Lai, MacRae, & Shakir, 1992; MacDonald, 1998; Pope-Davis, Prieto, Whitaker, & Pope-Davis, 1993; Wells, 1996), and recently, a few books on the subject have been published (Bonder, Martin, & Miracle, 2002; Wells & Black, 2000). This increased awareness and practice of cultural competence and culturally competent care has been supported by recently published national standards for cultural competence (US Dept. of Health and Human Services, 1999). But the question remains, "How does one become a culturally competent practitioner?"

I agree with Zeller (1995) when she states that "it is the responsibility of the educational institutions in the United States to nurture cultural sensitivity . . . by providing students the opportunity to explore and examine other cultures as well as

their own'" (p. 9). I believe this is especially true in health professions' education, where faculty not only facilitate the learning of specific professional content, but also seek to acculturate the students into the guiding philosophies of the professional organization (Curry, Wergin, & Associates, 1993). Some of these guiding philosophies in the profession of occupational therapy include a belief in inclusion and equality of all people (AOTA, 2000), and the centrality of client-centered care (Law, 1998). These professional precepts provide the foundational rationale to facilitate the development of cultural competence in occupational therapy students. Helping occupational therapy students develop cultural competence is a challenge for today's educational programs. Yet the expectation to do so is there. In the latest revision of the national standards for educational programs (American Occupational Therapy Association, 1998) there are two standards which specifically address issues related to culture and diversity.

* Standard B.1.7 (The student will) Demonstrate knowledge and appreciation of the role of sociocultural, socioeconomic, diversity factors, and lifestyle choices in contemporary society. (p. 6)

* Standard B.4.6 (The student will) Consider factors that might bias assessment results, such as culture, disability status, and situational variables related to the individual and context. (p.7)

There are numerous others that address understanding the "social condition" (B.1.8), "social factors" (B.6.3, B.7.2) and "social models" (B.6.5., B.7.1) that influence occupational choice and the delivery of occupational therapy practice (American Occupational Therapy Association 1998).

These standards are quite general, and do not specifically address cultural competence, yet they do assure that every occupational therapy student will at least be introduced to the concepts of culture and diversity. Typical of educational standards, they fail to indicate how that can or should happen. There is no

standardized approach to teaching about these issues, and there are no specific expectations for student outcomes.

As occupational therapy education programs continue to teach about diversity in an effort to foster cultural competence, it becomes increasingly important to research the results of that effort. Only a few occupational therapy research studies examine aspects of cultural competence (Bailey, 2000; Forwell, 2000; Forwell, Whiteford, & Dyck, 2001) that actually ascertain how the students perceive of, understand and experience the phenomenon. Seeking answers in the occupational therapy literature has been frustrating because of the limited number of studies published.

I, therefore, turned to the literature in other health fields, particularly nursing, social work, and clinical psychology. These were chosen, not only because of their similarity to occupational therapy, but also because these three professions have all contributed significantly to the literature on cultural competence. The information found in the following literature review was illuminating because the majority of the research studies were empirical designs where data was gathered through surveys. (See chapter 2). Very few studies ask students to describe in their own words or *voice* how they understand or experience cultural competence. I felt that this was a significant gap in our understanding of how students perceive of, experience, and understand the concept and how to apply it.

The Research Question and Study Design

The research question I am exploring in this study is " How do occupational therapy students "voice" their perception, meaning of, and experience with culturally competent interactions and culturally competent care at the end of their academic experience?" As was stated earlier, the majority of research on cultural competence includes empirical quantitative studies that rarely ask for personal stories or narratives. Because I am interested in the experiences occupational therapy students have had with cultural competence, and the meaning of these experiences

for these students, this study is designed as a phenomenological examination using methodology outlined by Moustakas (1994). The purpose is to understand the "essence" of cultural competence and culturally competent care as perceived and described by occupational therapy students.

Purpose of the Study

My research question initially came from my desire to contribute to outcome research on occupational therapy education, particularly as it relates to culture and diversity. At the end of an occupational therapy academic program, how do students understand and experience the phenomenon and concept of cultural competence? This phenomenological study will contribute to the professional dialogue in occupational therapy on cultural competence. This qualitative analysis of students' perceptions will give insight into the experiences of students. Knowing how students make meaning of the concept and experience of cultural competence will help inform occupational therapy educators' teaching practices. This study will describe a) how some students perceive, understand and experience cultural competence, and b) determine if students' experiences and language reflect the manner in which the concept is developed in the literature. It is expected that this study will assist occupational therapy educators in creating more effective teaching/learning approaches regarding diversity, multiculturalism, and cultural competence.

CHAPTER 2

CULTURAL COMPETENCE:

A LITERATURE REVIEW

The changing demographics of the United States continue to indicate a rise in the numbers of non-Whites while the numbers of poor and working poor have also increased. Additionally, the general population is increasingly aging, and people who live an alternate lifestyle are more and more open about their choices (U.S. Dept. of Health and Human Services, 1997). The explosion of diversity in our society has resulted in a rising awareness of the importance of cultural competence. In the social science and health professions' literature in particular, cultural competence is a concept that is increasingly investigated and written about. However, it is not easily defined. Not only does cultural competence mean different things to different people and disciplines, the components of cultural competence seem to be many and varied. Trying to understand the skills and characteristics that make up a culturally competent professional person can be confusing. Therefore, trying to validate, describe, operationalize and reconstruct those skills and characteristics through research can be difficult.

This chapter will first discuss the necessity for cultural competence in health care, explore some of the definitions of cultural competence, and identify the more salient and currently agreed upon characteristics and skills of a culturally competent person. Secondly, it will examine some of the methods found in the literature to educate for cultural competence. It will then examine cultural competence and occupational therapy, and finally will identify and analyze the research on cultural competence in healthcare, making a case for a qualitative analysis of this concept.

Why Cultural Competence?

"Cultural competence is increasingly being seen as important to quality of care" (Chin, 2000). Managed care has changed the way health professionals do business. Instead of having weeks and months to develop rapport with a client/patient, practitioners find themselves challenged by the task of providing the best possible service in an often too brief period of time. Both evaluation and intervention time frames have been shortened to sometimes include only a few days to a few weeks of reimbursable care. Chin (2000) reports that "Few demands have been made of managed care organizations to be more responsive to diverse groups in their policies and procedures" (p. 115). Despite these realities, health professionals, including occupational therapists, are exhorted to provide client-centered care as the most effective and best quality care. Client-centered care recognizes each client as a unique individual who contributes towards his/her own problem and goal definition as part of the intervention process (Canadian Association of Occupational Therapists, 1991). In order to recognize and honor each client's unique nature, practitioners must be sensitive to and knowledgeable about that person's cultural beliefs and background, because these will impact his/her response to illness and wellness, and will define the sick role for that person. Therefore, client-centered therapists must develop cross-cultural skills; they must be culturally competent.

Abney (1996) argues for the importance of cultural competency when she states, "Cultural identification has a crucial impact on an individual's response to traumatic stress. Therefore cultural identification must be considered carefully when addressing practice issues. . . It determines the individual's view and disclosure of the trauma, expression of symptoms, and attitude toward treatment and recovery" (pp.409-410).

Abney (1996) identifies the importance of practitioner cultural competence for the client. Others speak to the importance for the practitioner. Brislin, Cushner, Cherrie, and Yong (as cited in Lynch and Hanson, 1998) identify cross-cultural

competence as important "to assist interventionists to a) feel comfortable and effective in their interactions and relationships with families whose cultures and life experiences differ from their own, b) interact in ways that enable families from different cultures and life experiences to feel positive [sic] about the interactions and the interventionists, and c) accomplish the goals that each family and interventionist establish" (Chapter 3, no page number).

While making the case for the importance of cultural competence, several authors address the consequences of cultural **in**competence. McPhatter (1997), referring to the field of child welfare strongly states, "The current level of cultural incompetence can persist only at vast detriment to children, families, communities, the child welfare system, and society as a whole" (p. 274). She goes on to state that incompetently developed programs "often exacerbate the very problems they aim to ease," . . . "pursue erroneous targets, squander scarce resources, and help few" (p. 274). A report on *Cultural competence practice and training: Overview* (retrieved from the world wide web from http://www.diversityrx.org/HTML/MOCPT1/htm. on February 22, 2000) discusses multiple consequences of the lack of cultural competence. The author identifies the following:

* Patient-provider relationships are affected when understanding of each other's expectations is missing.
* Miscommunication
* Patient may not follow instructions
* Patient may reject the provider because of non-verbal cues that do not fit expectations

In all of these examples, quality of care is compromised, perhaps even to the point of providing an unsafe environment for the client. Additionally, there is increased frustration in both the client and the provider, resulting in an unsatisfactory health care experience for all parties. These consequences may be avoided if practitioners work towards the development of cultural competence.

Cultural Competence Defined

In order to understand the meaning of cultural competence, we must examine the word *culture.* A definition I prefer, and have used in an earlier publication (Wells & Black, 2000, p. 279) is the following:

> *Culture is the sum total of a way of living, including values, beliefs, standards, linguistic expression, patterns of thinking, behavioral norms, and styles of communication that influence the behavior(s) of a group of people that is transmitted from generation to generation. It includes demographic variables such as age, gender, and place of residence; status variables such as social, educational, and economic levels; and affiliation variables.*

This inclusive definition is not consistently found in much of the literature on cultural competence, however. The majority of papers and research studies appear to focus mainly on the characteristics of race and ethnicity when identifying cultural characteristics for examination.

In researching the definition of cultural competence, it might be instructive to determine when the phrase was first coined. Early in the twentieth century the concept of *cultural tolerance* was used to describe the goals of working with and educating those who were culturally different from white Americans (LaBelle & Ward, 1994). In the 1960's, as a result of the influence of the Civil Rights movement and the community health and mental health movements, mere tolerance to difference was recognized as a limited concept, and *cultural sensitivity* was emphasized as a more effective attitude and goal when providing services to immigrants and non-English speaking minority groups and people of color (Chin, 2000). It wasn't until the 1980's that the focus shifted from cultural sensitivity to *cultural competence.* Madeleine Leininger, a nurse-anthropologist who is known for the development of transcultural nursing, asserts that she was the originator of the construct and the term cultural competence (Leininger, 1994). The term competence

seems to indicate the development of particular skills when interacting within cross-cultural situations. Chin (2000) states that although being sensitive to and knowing about the culture of others continues to be important, "this transformation to a skill focus resulted in efforts to operationalize those components necessary to achieving cultural competence at a system level" (p. 25).

Competence is an apt term for this particular concept. Synonyms found in *The Merriam Webster Dictionary* (1995) include "capable," "fit", and "qualified" (p.107). This connotes that some people may have a certain capability to perform a particular task. Does this then mean that certain abilities make a person more qualified for a task? Does it mean that effective cross-cultural interactions occur only between people who are somehow more qualified than others? Hager and Gonczi (1996) discuss an "integrated conception of competence." Within their discussion, "competence is conceptualized in terms of knowledge, abilities, skills and attitudes displayed in the context of a carefully chosen set of realistic professional tasks" (p. 15). Given this conceptualization of competence, and combining it with the dictionary definitions, one can conclude that a person must hold particular knowledge, abilities, skills and attitudes regarding sociocultural issues in order to be "qualified" as culturally competent.

According to Hager and Gonczi (1996), it is precisely this integrated view of competence that emphasizes not only the abilities and skills of a person, but also the personal attributes and attitudes of that person, that moves the concept beyond that of being purely skill-based. Many people can learn particular skills for a task, but Hager and Gonczi emphasize the importance of personal beliefs and attitudes for full competence (in any task) to occur. "Just as abilities or capabilities [are] necessary, but not sufficient for competence, so the performance of tasks is also necessary, but not sufficient for competence. Thus any satisfactory account of competence must include both attributes and tasks" (p.16). They perceive the concept of competence as relational. "Competence is essentially a relation between abilities or capabilities of people and the satisfactory completion of appropriate task(s)" (p. 16). Many of the definitions of cultural competence found in the literature, however, don't

necessarily seem to subscribe to the relational conceptual viewpoint of competence described by Hager and Gonczi.

In the occupational therapy literature, cultural competence has been defined as people "moved from being culturally unaware to being sensitive to their cultural issues and how their values and biases affect racially different patients/clients" (Pope-Davis, Prieto, Whitaker, & Pope-Davis, 1993, p.839). It is also described as "the process of actively developing and practicing appropriate, relevant, and sensitive strategies and skills in interacting with culturally different persons" (AOTA Multicultural Task Force, 1995).

Within counseling psychology literature, Stanley Sue (1998, p 440) states that cultural competence "is the belief that people should not only appreciate and recognize other cultural groups but also be able to effectively work with them." Abney (1993) writes, "cultural competency is the ability to understand, to the best of one's ability, the world view of our culturally different clients (or peers) and adapt our practice accordingly" (p. 411). Following a lengthy concept analysis of the term cultural competence, Smith (1998) derives this definition from a study of the nursing and health care literature. "Cultural competence is a continuous process of cultural awareness, knowledge, skill, interaction, and sensitivity among care givers and the services they provide" (p. 9).

The definition most often quoted in the literature, however, comes from Cross, Bazron, Dennis, and Issacs in a monograph entitled, *Towards a culturally competent system of care, vol. 1,* (1989). Cross et al. define cultural competence as a "set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations" (p. 13). This definition is more in harmony with Hager and Gonczi's (1996) relational concept of competency, particularly as Cross et al. emphasize the congruence of the attributes of cultural competence, and the manner in which they "come together" for effective care. Perhaps this definition is more often used because it is broader, moving the concept of cultural competency beyond individuals and into organizations and communities.

It supports the examination of the climate of an organization and the policies that enhance or diminish a climate of competency.

In all of the definitions above, the concept of *action* is a common component of cultural competence. It is not always clear, however, what specific action is required. In the occupational therapy definition, *practicing . . . strategies and skills* is underscored. Counseling psychology emphasizes *effectively work[ing]* with people or *adapting our practice*, while Cross et al. identify *congruent behaviors* as an important aspect of cultural competency. According to these definitions, in order to be culturally competent, a person must actually do something. It is not a concept that is passive in nature. One wonders, therefore, what is it that a person or agency actually has to do to be recognized as culturally competent. What, exactly are the characteristics of cultural competency? How would we know a culturally competent person if we saw one?

Attributes of Cultural Competence

Although there are multiple theories within the literature, most authors agree that there are predominantly three major characteristics or attributes of cultural competence: **self-awareness/attitudes, knowledge, and skills** (Kavanagh & Kennedy, 1992; Lynch & Hanson, 1998; Pedersen, 1988; Pedersen & Ivey, 1993; Wells & Black, 2000).

Self-Awareness

Individuals with cultural **self-awareness** critically know and understand themselves at a confident level that allows them to be vulnerable and to take risks in cross-cultural interactions. They also recognize the need for and seek out additional knowledge about groups that are different from themselves. Leonard and Plotnikoff (2000) refer to self-awareness as the "heart of cultural competence" (p. 51).

According to Pope-Davis and Coleman (1997), "a desire to explore one's

identity as a person who has been socialized in a culture, race, and ethnicity is characteristic of [those] who are committed to developing multicultural competencies" (p.9). This critical self-examination allows a person to carefully study her culture, racial identity and world view, as well as the role she plays in a racialized world. She reflects on how she values and responds to people who differ from her in age, gender, class, sexual orientation, and ability. This process of self-discovery allows the practitioner not only a sense of self in a diverse world, but an openness that enhances her empathy with those from different cultural backgrounds. Analyzing oneself is not always easy, especially for those practitioners who hold characteristics of the dominant societal group; those who are white, upper-class, financially secure, able-bodied, heterosexual, and male. It necessitates recognizing and grappling with one's own unearned privilege (McIntosh, 1988) and thinking about how that may impactclient/practitionerinteractions.

Some believe that **self-awareness** is the necessary first step in the journey towards cultural competence (Chan, 1990; Harry, 1992; Lynch & Hanson, 1998; Weaver, 1999; Wells & Black, 2000). Culturally aware individuals recognize their own culture and social location and know how it influences their values, beliefs, behaviors, and choices; they are comfortable with cultural differences between themselves and others; and they are sensitive to issues of culture in all interactions (Wells & Black, 2000). In healthcare when working with clients from other cultures, "students must be able to acknowledge their own cultural backgrounds and not feel threatened by their own cultural identifications, especially when they differ with that of the clients" (Chau, as stated in Sowers-Hoag & Sandau-Beckler, 1996, p.43). Cultural self awareness "is the bridge to learning about other cultures" (Lynch & Hanson, 1998, p.55), and Gerrish and Papadopoulos (1999) suggest that "the starting point of any education programme should therefore be an exploration of the students' own cultural values, beliefs, and practices, including their own prejudices" (p.1454).

McPhatter (1997) refers to this increased self-awareness as "enlightened consciousness." She believes that it is a fundamental transformational process that

results in the "reorienting [of] one's primary worldview" . . . "It often requires a radical restructuring of a well-entrenched belief system that perceives oneself and one's culture, including values and ways of behavior, as not only preferred but clearly superior to another's. The ultimate goal of this shift in mind-set is to create a belief in, and acceptance of, others on the basis of equality solely because of a sense of shared humanity" (pp. 262-263). McPhatter is not talking about simply completing a few self-awareness exercises. Rather, she emphasizes the gravity of this work, and the need for ongoing and sustained practice. "It should be apparent that this dynamic process cannot even begin in short-term or brief overtures into another's world. It must be a sustained effort motivated by a true desire to become accepting and comfortable in personal cross-cultural interactions and effective in providing services to clients whose cultural realities differ markedly from one's own" (p. 264).

Although it was stated above that self-awareness may be the first step in the development of cultural competence, in actuality full self-awareness may develop as a result of gaining knowledge about others and the world in which one lives in a more interactive or transactive process. Although learning about oneself as a cultural being may result in an interest in learning about those who are different from oneself, the opposite sequence may also occur. Gaining knowledge about other groups of people may also facilitate greater self awareness.

Knowledge

Knowledge is the second major characteristic of cultural competence, and can mean specific knowledge about the culture of one's clients (Pedersen & Ivey, 1993). It can also mean having an understanding of the sociocultural role of minorities in the dominant culture, and recognizing the barriers to healthcare access for many non-dominant groups (Wells & Black, 2000). It may mean learning the language of your clients (Lynch & Hanson, 1998) or knowing which community agencies are supportive of your clients' needs. Being culturally knowledgeable also means having a clear and explicit understanding of your own field (Pedersen & Ivey, 1993),

the concept of client-centered practice, and the awareness of how you can effectively provide the best healthcare possible for all clients no matter what their culture.

McPhatter (1997) states that the following list provides a foundation for a "grounded knowledge base" necessary for cultural competence.

1. Knowledge of the history, culture, traditions and customs, preferred language or primary dialect, value orientation, religious and spiritual orientations, art, music, and folk or other healing beliefs of your clients
2. Intimate familiarity about social problems and issues that have different impacts on minority group members.
3. Knowledge of the clients' neighborhoods and communities in recognition of the importance of context as influential in a person's life
4. Firm understanding of the dynamics of oppression, racism, sexism, classism, and other forms of discrimination
5. Knowledge of health and social systems and their impact on disadvantaged groups
6. Awareness of diversity of family structure and the often overlooked functionality of diverse family forms
7. Knowledge of culturally relevant interventions employed within the professional structure (pp 266-270)

McPhatter's list is broadly based, thorough, and overwhelming in its breadth. What it does not do, however is to give specifics on how one accrues this knowledge. Lynch and Hanson (1998) suggest that four of the most effective ways to access cultural knowledge are, "1) learning through books, the arts, and technology; 2) talking and working with individuals from the culture who can act as cultural guides or mediators; 3) participating in the daily life of another culture; and 4) learning the language of the other culture" (p. 55). Interestingly, Lynch and Hanson do not stress the need for cultural immersion, but view participation within a culture as just one of many ways to gain cultural knowledge.

Lynch and Hanson (1998) warn against memorizing lists that depict differences between various cultures as a way to gather information. Instead, they propose that practitioners "consider value sets that are common across cultures and view each as a continuum" (p. 57). In this way perspectives don't have to be polarized or mutually exclusive, and individuals may fall anywhere on the continuum. Lynch and Hanson also suggest seven cultural continua to explore when learning about clients or the cultural groups to which they belong. These include:

1. the family constellation continuum - which includes kinship networks and the amount of support offered
2. the nurturance/independence continuum - which determines the values related to how long children are nurtured or encouraged to be independent
3. the time continuum - how individuals or groups perceive time
4. the traditional/technology continuum - which explores whether people look to the past, present, or future to determine what is important in life
5. the ownership continuum - which looks at property rights
6. the rights and responsibilities continuum - which considers equal rights and responsibilities and differentiated rights and responsibilities
7. the harmony/control continuum - which explores whether people want to live in synchrony with their surroundings and circumstances, or whether they want to have control over their surroundings and circumstances (pp.58-63).

Lynch and Hanson (1998) believe that if a practitioner can understand where a client falls on these continua, and if that same practitioner is aware of her own values in relationship to these continua (self-awareness), the opportunity for effective cross-cultural interactions within practice settings will be enhanced and one will positively move towards cultural competence. However, as important as self-awareness and knowledge are, they are more or less meaningless unless one develops cross-cultural skills and behaviors. Culturally competent behaviors are the way that one's awareness and knowledge is applied.

Skill

The third characteristic of cultural competence, cross-cultural **skill**, is most often described as effective communication skills. Pedersen and Ivey (1993, p. 18) discuss a three-stage developmental framework of competencies with skill-learning being the final stage. They state that culturally skilled [practitioners] can:

1. generate a wide variety of verbal and nonverbal responses appropriate to a wide range of cultures
2. both send and receive verbal and nonverbal messages accurately and appropriately to or from culturally different people, and
3. change the system or institution on behalf of a client when the individual is right and the system is wrong.

These are fairly broad statements, and without specific examples, they do not clearly articulate observable skills. One skill defined by Stanley Sue (1998), has been more thoroughly discussed. He uses the term 'dynamic sizing' to mean that "the therapist has appropriate skills in knowing when to generalize and be inclusive and when to individualize and be exclusive" (p.446). Sometimes specific knowledge about another culture results in stereotyping, where each person of that culture is recognized as having the same characteristics, traits or behaviors. Appropriate dynamic sizing "allows one to avoid stereotypes of members of a group while still appreciating the importance of culture" ... "the therapist is able to place the client in a proper context - whether that client has characteristics typical of, or idiosyncratic to, the client's cultural group" (Sue, 1998, p. 446).

Wells and Black (2000) are more pragmatic in approach when they discuss multicultural or cross-cultural skills. They state that skill "refers to acquiring as well as mastering strategies, techniques, and approaches for communicating and interacting with persons from different cultures." They go on to give specific examples such as "telephone behaviors, receptionist practices, client interactions that build trust, establish credibility, and help create culture-friendly environment" (p. 181). Skilled communication patterns include "articulating the problem, managing resistance and

defensiveness, and recovering when mistakes are made" (p. 182). Cross-cultural skills that are vital for effective multicultural communication also include empathizing and understanding others' beliefs, assumptions, perspectives, and feelings.

Lynch and Hanson (1998) develop these concepts even further. They suggest that effective cross-cultural interaction takes place when a practitioner understands whether the client is from a high-context or low-context culture and uses that knowledge with appropriate communication patterns. A high-context culture is one where group interactions and strong, cohesive interpersonal bonds, and emotions are valued, whereas low-context cultures value individualism, objective and analytical thinking (Bennett 1995). Lynch and Hanson (1998) describe the importance of being skilled in recognizing and engaging in nonverbal communication including the significance of eye contact and facial expressions, proximity and touching, body language and gestures (pp. 70-74). They also emphasize that cross-cultural skill includes listening to the client's perspective in an effort to see the world the way the client does, and acknowledging and respecting cultural differences rather than minimizing them (pp. 74 & 75).

The authors do summarize that learning these skills is not easy."Unfortunately, there are no shortcuts and there is no magic wand. Acquiring the skills is a lifelong process; however, desire, willingness to learn, and the potential outcomes for [clients and practitioners] alike make it a rewarding pursuit" (Lynch & Hanson, 1998, p. 84). McPhatter (1997) points out that skill proficiency develops only through a systematic process. "Skill proficiency is not a haphazard process; it is focused, systematic, reflective, and evaluative. Continuing to use skills because we were trained that way or because we lack alternative skill proficiency is out of sync with the goal of achieving cultural competency" (p. 272).

Each of the three characteristics discussed above is of vital importance in the development of cultural competence. Pedersen and Ivey (1993) summarize it in this way. "If any of the three stages of awareness, knowledge, or skill is missing from their [practitioners'] training, difficulties are likely to arise. If they neglect awareness, they are more likely to build on wrong or inappropriate assumptions. If they neglect

knowledge, they may be inaccurate in their description of a situation. If they neglect skill, they may well be changing the situation in counterproductive directions" (p.19). Rather than viewing these attributes as sequential, Weaver (1999) believes that these three components of cultural competence; self-awareness, knowledge, and skills, are interactive. She states, "none is sufficient in and of itself to bring about appropriate practice" She goes on to state that "striving for cultural competence is a long-term, on-going process of development" (p.218).

An important point to emphasize from the above, is that becoming culturally competent is not an easy task. Rather, it is challenging, and may be a life-long process (Gerrish & Papadopoulos, 1999; Harris & Cummings, 1996) In fact, many characterize the journey towards cultural competence is arduous and complex (Lynch & Hanson ,1998; McPhatter, 1997; Weaver, 1999). It is a "developmental process in which one learns to recognize, value and adapt to diversity; assess one's own knowledge, attitudes and beliefs about others' cultures; and incorporate the patient's beliefs and practices into the health care encounter. Patients perceive services as being culturally competent when they are appropriate for their problems and helpful in achieving desired outcomes according to their explanatory belief models" (Dana, as cited in Kramer, Ivey, & Ying, 1999, p.20).

Yet, as extraordinary as this task is, it must start somewhere. Recognizing the attributes of a culturally competent person is the first step. That knowledge then challenges occupational therapy educators with the question, how does one learn to become culturally competent? What type of training/education has been used successfully with students and others who wish to gain expertise in these multiple areas? Is a certain educational approach more effective than others? The next section of this chapter will address these questions.

Methods of Training/Education for Cultural Competency

Given the compelling need for a culturally competent work force in the health professions, it is not surprising that authors stress the development of effective

education that will address these issues (Dyck, 1991). Zeller (1995) states that "it is the responsibility of the educational institutions in the United States to nurture cultural sensitivity . . . by providing students the opportunity to explore and examine other cultures as well as their own'" (p. 9). This is especially true of health professions' education.

Health professions' education is governed by accreditation councils which develop and maintain educational standards for each profession. Accreditation standards for many professions include statements regarding culture, diversity or multiculturalism but may differ in depth and specificity. From professions such as Rehabilitation Counseling that required no multicultural training in their standards even less than a decade ago, (Smart & Smart, 1992), educational standards range to the very detailed. The American Physical Therapy Association standards include general statements such as "physical therapy graduates should consider social and cultural factors while collaborating with patients and their families" (Commission on Education in Physical Therapy Education as cited in Monahan, 1997). This is similar to the very general standards found in the *Essentials and Guidelines for an Accredited Occupational Therapy Education Program* (The American Occupational Therapy Association, 1998). In contrast, the social work profession, which has been grappling with the issue of diversity since the 1950's, has developed specific accreditation standards which not only require multicultural training, but also ban ethnic, racial, and religious discrimination with respect to the selection of students, faculty, field instructors and other staff; ban gender discrimination; support affirmative action and work toward social justice (McNicoll, 1999).

The National League of Nursing has also mandated inclusion of content on cultural diversity within nursing curricula (Beverly, 1992), and in 1992, the American Academy of Nursing's Expert Panel on Culturally Competent Nursing Care made specific recommendations regarding strategies for teaching and guiding faculty and nursing students to provide cultural-specific nursing care. (Campinha-Bacote, 1998). This emphasis is not surprising given the nursing profession's early emphasis on transcultural nursing (Leininger, 1978).

But the profession from which much of the cultural competency literature is generated, Counseling Psychology, continues to struggle with appropriate standards. Sue, Arredondo, and McDavis (1992) reported that although 89% of counseling psychology education programs offer a multicultural course (p. 477), the educational standards at that time did not provide a clear mandate to do so. The authors identified a lack of multicultural statements in the standards and guidelines of the American Association for Counseling and Development, and offered a call for action that would add specific standards addressing these areas (Sue, Arredondo, & McDavis, 1992).

Although professional mandates do not always translate into practice, over the past decade much has been written regarding the training and education for cultural competency. Multiple models delineate numerous approaches used to educate health professionals in an effort to facilitate cultural awareness, sensitivity, knowledge and skills necessary for effective practice within a diverse society. One strategy for organizing this array of information is to examine what approaches are being used within particular health professions. I will do so by reviewing literature from nursing, social work, and counseling psychology. These three professions were chosen to examine because of their significant body of literature on cultural competence. Occupational therapy will be examined in a separate section of this chapter.

Nursing Education

Nursing has been involved with multinational and multicultural groups as early as Florence Nightingale's involvement in Crimea and with the Australian aboriginals in the early nineteenth century (Hagey, 1988). But it wasn't until 1974 when Madeleine Leininger combined the concepts of nursing and anthropology to found the sub specialty of transcultural nursing (Leininger, 1978) that the concept of culture became an area of study in the nursing profession. Almost two decades later, Andrews (1992) worried that these educational efforts had made little impact. She

reported, "only a handful of nursing programs have integrated cultural concepts into the curriculum, despite considerable rhetoric about the issue and the availability of guidelines to assist faculty" (p. 10). She goes on to say that the cultural terminology is incorporated into curricular documents and even some texts, but these concepts are not fully developed by authors or faculty.

Perhaps one of the reasons the integration of this material has been so slow in forthcoming is that transcultural nursing has tended to look at culture from an observers point of view, rather than engaging the students and faculty in the self assessment necessary for cultural competence. Sims and Baldwin (1995) state that "the predominant education model in nursing's literature focuses on teaching the exceptional and culturally different student" (p. 318). Although this approach in itself is sometimes seen as racist, classist, and sexist, it is also believed to be a viable and effective way to learn about people different from oneself. Certainly the work by Spector (1996) which provides continually updated information about different cultural groups and their health care practices and beliefs offers much needed information to the White health care practitioner who is yearning to understand more about her Vietnamese client. This knowledge is important in order to provide culturally competent health care. However, if not used carefully and with sensitivity, that information can be misused in a stereotypical manner, masking the unique identity of the client in a way that is indeed racist.

Not all nurse scholars view curriculum inclusion of culture and diversity in the way outlined above, however. McGee (1992) writes that it is "neither practical nor desirable to attempt to teach students about many different cultures. The aims should rather be on developing a set of principles that equip the nurse to care for people, not just of one culture but of many different ones" (p. 18). Lenburg and her colleagues (1995) refer to this as a generic versus a specific approach to addressing cultural characteristics. The *generic approach* "focuses on universal categories that are used to describe various cultural groups, e.g., world view, non-verbal communication, language, and family structure, using different cultures to illustrate variations. The *specific approach*, in contrast, focuses on one or more ethnic

or immigrant groups, providing a cultural description that includes cultural traits, behaviors, communication patterns, and the like" (p. 9). More currently, Gerrish and Papadopoulos (1999) state that merely knowing about other cultures is insufficient. "In order to provide effective health care in a multiethnic society, practitioners also need to understand the complex way in which historical, political, social, and economic factors interact and impact on the experiences of minority ethnic communities" (p. 1454). They believe that in order to be culturally competent, practitioners must develop both generic and specific cultural competence. Gerrish and Papadopoulos go on to state that the starting point of any education program should be self-exploration and awareness. Recognizing the importance of evaluating one's own cultural values as part of becoming culturally competent has been identified by several authors in the nursing literature (Carpio & Majumdar, 1991; Lea, 1994; Lynam, 1992; McGee, 1994; Tuck & Harris, 1988).

Although there is developing agreement on this point and other aspects of culturally competent education, there is less agreement on the method to achieve these goals. The American Nursing Association (ANA) addressed inclusion of cultural content in nursing curricula in 1986 by identifying four approaches that nurse educators might employ.

1. **the concept approach** refers to the integration of cultural concepts throughout the entire nursing curriculum;
2. **the unit approach** refers to the inclusion of cultural aspects of nursing care in a specific unit or units;
3. **the course approach** refers to the offering of a specific course in which the emphasis is on the cultural aspects of nursing care; and
4. **the multidisciplinary approach** refers to the team-teaching of cultural content by nursing faculty, anthropologists, medical sociologists, and others involved in health care. (Andrews, 1992, p. 13; McGee, 1992, p. 15).

Although these guidelines provide a framework for faculty, Andrews (1992) believes they "fail to provide sufficient depth for the majority of faculty using them"

(p. 11). McGee (1994) critically assesses the unit and course approaches, stating that although they may be the easiest way to implement curricular change without undue cost and effort, they can also be viewed as basically tokenist and potentially racist, as they often do not address in-depth issues such as prejudice or competence. The approaches listed above may give a broad overview of multicultural curricula, but the choice of content and teaching strategies is left to programs and faculty to determine. A selection of specific models and curricula related to diversity and cultural competence found in the nursing literature are discussed below.

Despite McGee's (1994) critique of the use of specific courses to teach cultural competence, Abrums and Leppa (2001) discuss the revisions they have made to broaden the meaning of cultural competence for students in a course entitled "Nursing Care and Cultural Variation." They use Friedman's theory of relational positionality "to help students recognize that everyone has a perspective through which they view the world as 'normal'; and that normal as defined by the dominant group can create situations of oppression for others" (p. 270). Relational positionality helps students to recognize that all people maintain many contradictory social positions at any one time. "For example, a middle-class Black woman who is privileged by class but not by race may be viewed as a member of the oppressor group by a poor Black woman struggling with the welfare system; [while] a gay, White, upper-class male may be privileged by race, class, and gender, but a victim in a heterosexist environment" (p. 271). Using this theory as a guide for teaching cultural content helps to "increase student self-awareness in relationship to issues of discrimination and oppression in health care" (p. 271) and stretches their thinking about people different from themselves.

Taking a broader view of curriculum is Giger and Davidhizar's Transcultural Nursing Assessment Model (Davidhizar, Bechtel, & Giger, 1998; Davidhizar & Giger, 2001; Dowd, Giger, & Davidhizar, 1998). As part of this model, the authors developed a cross-cultural assessment tool in response to the need for an appropriate method to evaluate "cultural variables and their effects on health and

illness behaviours" (Dowd, Giger, & Davidhizar, 1998, p. 120). Giger and Davidhizar's model is built on the premise that health professionals must have access to culturally relevant information in order to deliver culturally sensitive and competent care. The assessment tool evaluates six cultural phenomena including "1) communication, 2) space, 3) social organization, 4) time, 5) environmental control, and 6) biological variations" (Dowd, Giger, & Davidhizar, 1998, p.121). This popular approach has been addressed in numerous articles and in a textbook entitled *Transcultural Nursing: Assessment and Intervention* (Giger & Davidhzar, 1999), and according to the authors, was designed for use by other health professionals as well (Davidhizar, Bechtel, & Giger, 1998). In contrast to this approach, McGee (1992) states that "the concept of assessing 'culture' as an element separate from the psychological, sociological, and other domains is a form of bias in itself, highlighting the idea of culture as a problem created by 'them' - ethnic people - who are different from 'us' - the dominant culture" (p. 56).

Within their model, Davidhizar and Giger (2001) emphasize the importance of the concept approach outlined by Andrews (1992) above, stating that "while there is specific focus on the phenomena in specific courses, all faculty assume responsibility for integrating culture as a thread throughout individual courses in the curriculum" (p.283). They emphasize the need for integrating culture throughout the curriculum "to achieve educational outcomes related to cultural competency" (p. 284).

Two other models or educational projects found in the nursing literature are the MELTING project by Sookhoo, Adams, and Anionwu (2000), and Project Cultural Competence (Jones, Bond, & Mancini, 1998). MELTING is an acronym for multiethnic learning and teaching in nursing, and the goal of the MELTING project is "to identify resources and strategies for teaching and learning culturally competent care" (p. 41). This is a three-phase project that will culminate in the production of teaching and learning resources that will facilitate learning about the needs of ethnically diverse people. The investigators will attempt not only to add to the knowledge base of nursing students and faculty, but also "to enable nurses to acquire and develop skills which help them care for patients in a culturally sensitive manner" (p.

41). Although the information about this project was somewhat limited, nowhere did it mention the facilitation of self-awareness for either faculty or students.

Similar to the MELTING project in goals (the development of knowledge and cross-cultural skills) but very different in process is Project Cultural Competence (Jones, Bond, & Mancini, 1998). This collaborative project combined the resources of three major community systems: education, health care, and the business sector of the community (Dallas, TX) in an effort to develop cultural competence among health care providers. There are two major learning components of this project. They include a "short-term continuing education cultural immersion program consisting of language and culture learning experiences in Cuernavaca, Mexico" (p.282) and a nurse exchange program between a local hospital system and the Instituto Mexicana Seguro Social Hospital in Cuernavaca. The University of Texas at Arlington School of Nursing provides didactic cross-cultural academic programs and a "Travel, Study, Learn program that sponsors the 1-week-long immersion experience in Mexico. The hospital system provides Spanish lessons, and health care personnel that take advantage of the University immersion experience as well as the nurse exchange program, while the community system provides housing and resources for the nurse exchange program. While evaluations of this project have been extremely positive, the authors recognize that this is only one approach to dealing with cultural competency training, and is biased towards learning about another culture and the development of basic cross-cultural skills. They state that "these initial, one-time, short-term immersion experiences teach individuals how to study culture and thrusts them into a life-long learning process about other cultural groups...[However], these initiatives are essential but also not sufficient to meet the health workplace needs" (Jones, Bond, & Mancini, 1998, p.286). They go on to state that multiple and varied training initiatives are necessary to develop a truly culturally competent healthcare work force.

As one reviews these various educational approaches in nursing, it becomes apparent that very few of the models are comprehensive in that they do not educate for all of the cultural competency attributes of self-awareness, knowledge and skills.

The following section will determine whether the social work profession is more successful in meeting this goal.

Social Work Education

Because of social work's commitment to social justice and equality, and their history of involvement in multicultural issues, one would expect a consistent academic approach to these issues. However, Kadushin and Egan (1997) discovered that although increasing diversity in the health care environment is a recognized trend, only 51% of social work schools surveyed in their study (N = 94) had course units that focused on multicultural issues. Despite the limited number of education programs that include diversity issues in their curricula, many have developed successful strategies and models for inclusion.

Lee and Greene (1999) discuss the importance of a social constructivist framework in their recent article. Constructivism adheres to the belief that learning is internal and that "the human mind plays an active role in organizing and creating meaning - in literally inventing rather than discovering reality" (p. 21). They continue, "In this process of socially constructing reality, individuals interpret, assign meaning, and create assumptions about themselves, other people, and their environment that provide the foundation for their knowledge of the world" (p. 22). The authors believe that one's cultural background plays a critical part in one's reality and how one co-constructs with others. They theorize that a constructivist approach to learning would assist students in developing a "culturally sensitive perspective of openness and acceptance to their clients' diverse cultural systems" (p. 26). The teaching framework for this approach consists of three components: an overview of constructivism; an exploration of culture and self; and a social constructivist approach to the help-seeking process of clients which is centered in practice. Lee and Greene (1999) conclude that this approach has its limitations but is one way to provide students with a theoretical basis for developing a culturally sensitive perspective of openness and acceptance of diversity.

Another curricular approach found in the social work literature is the Inclusionary Cultural Model described by Nakanishi and Rittner (1992). This model allows students to learn about culture from their own cultural experience. Students examine their own cultural heritage and values and compare these to those of the dominant culture and their own classmates. The final stage of the process is to introduce didactic material on various cultures. Nakanishi and Rittner (1992) developed this approach in order to "soften the exclusionary boundaries between cultural groups and allow students to become more open to a more etic approach to learning about and interacting with people of different cultural backgrounds" (p. 33). This model allows students to learn about culture from the familiar - their own culture. This personal approach to learning about culture maintains the students' interest, providing a learning experience that is not just theoretical, but makes meaning for them in a personal and effective way. The authors describe the Inclusionary Cultural Model as a "demonstrably successful teaching method" (p. 34).

A Values-Based approach by Uehara et al. (1996) "draws on fundamental values undergirding the profession and practice of social work: social justice, equality, self-determination, and empowerment" (p. 614). The ultimate goal of this approach is social transformation which occurs through reflection and collaboration. Self reflection is important because the person must "be constantly aware of how her or his own values, beliefs, behaviors, and customs may distort communication and promote domination. Therefore, constant introspection or self-reflection . . . is critical" (Uehara et al., 1996, p. 615).

It is interesting that a common theme through the above three approaches is the vital need for self-knowledge and self-reflection. As has been stated earlier, self-awareness is a very important component of cultural competence. However, unless combined with cross-cultural knowledge and skills, it is ineffective for cross-cultural practice. Ronnau (1994) and Sowers-Hoag and Sandau-Beckler (1996) offer more comprehensive views of multicultural education in social work.

Ronnau (1994) identifies and discusses *five strategies* for teaching cultural competence. These include:

1. *Introduce students to key definitions pertaining to cultural awareness and the culturally competent professional.* Within this category, Ronnau includes an emphasis on self-awareness and the importance of a commitment to the development of cultural competence. Additionally, students must recognize and accept the fact that significant differences do exist between people of different cultures, and that those differences will impact practice. Lastly, students must learn to gather more knowledge about a client's culture and to use this cultural knowledge to adapt their practice behaviors and develop new skills to meet the needs of their clients.

2. *Provide resources about the cultures to be discussed.* Ronnau supports the use of cultural profiles but emphasizes the importance of using them with caution. Although such resources do provide basic knowledge about cultural groups, if misused, they can also perpetuate stereotypes. Students must also be taught that each client is unique, and there is as much diversity within a specific culture as there is between cultures.

3. *Ask students to be cultural guides.* This strategy is most effective if there is diversity within the class. Class members are asked to volunteer for this role to assist their classmates to learn about other cultures. "Cultural guides are asked to provide samples of food, music, art and language which are important to them and represent their culture as they view it" (Ronnau, 1994, p. 35). It is stressed that no one person can accurately represent an entire culture, but classmates can represent their own personal backgrounds.

4. *Inform students about and encourage them to attend cultural awareness activities that are occurring on campus and in surrounding communities.* Announcing these events in class reminds students that cultural awareness is valued, is an ongoing process, and requires active involvement.

5. *Integrate multicultural content throughout the course(s).* "Multicultural education cannot be achieved by means of a few classroom activities. Becoming multicultural has to be seen as a process rather than a state of being" (Ronnau, 1994, p. 36). Becoming culturally competent is an ongoing and prolonged process that will not

occur as a result of a few classroom exercises. However, an effective integrated course can increase student awareness, whet the appetite for more knowledge, and begin the development of cross-cultural skills.

Although somewhat limited in skill development, Ronnau's strategies provide a more comprehensive approach to teaching cultural competence than seen in the nursing literature. Sowers-Hoag and Sandau-Beckler (1996) propose another comprehensive approach which is guided by their philosophy that "Developing cultural competence is a dynamic process of growth through ongoing questioning, self-assessment, knowledge and skill building starting with the students' level of current competence, and supporting enhancement of their abilities" (p. 39). What is unique about the model suggested by Sowers-Hoag and Sandau-Beckler (1996) is that multicultural content is integrated throughout a multi-course generalist curriculum that culminates in the fieldwork experience. Using a case example, the authors demonstrate how knowledge and skills learned in a variety of courses could be applied to the case, emphasizing the breadth and depth of cultural awareness, knowledge and skills. They discuss the importance of an "ethnic sensitive field work program" where students "can apply the culturally relevant knowledge and skills acquired in the classroom curriculum" (p. 49) but acknowledge the complexity of and the need for careful planning for the development of appropriate field sites. In conclusion, they exhort the Council on Social Work Education Commission on Accreditation to strengthen the educational standards beyond the level of "understanding diversity" to the development of cross-cultural skills necessary for culturally competent care, and also suggest that all doctoral social work programs "consider the inclusion of learning objectives . . . designed to promote culturally competent educators" (Sowers-Hoag & Sandau-Beckler 1996, p. 53).

Counseling Psychology Education

"Although the counseling profession's recent attention to multicultural issues is to be lauded, there is no clear consensus as to what constitutes a good multicultural

training program" (Ponterotto, Rieger, Barrett, & Sparks as cited in Sue, 1997, p. 175). This lament continues to be heard in counseling psychology despite the plethora of research and articles regarding diversity, cultural competence, and culturally competent care. Some of the confusion may result from the multiple ways that the term "multicultural" is defined within the profession. Some use a broad definition which includes factors such as age, ethnicity, gender, place of residence, socioeconomic and educational levels, nationality, and religious and sexual orientation. Pedersen and Ivey (1993) believe that all of the above are aspects of culture, and therefore are included in all counseling relationships. "Culture is not treated as an exotic or specialized aspect of counseling but rather as the heart and soul of any and all counseling relationships" (p.viii).

Others believe that this broad definition is so inclusive that issues related to racism might be lost (Sue et al., 1992) or impossible to investigate (Helms, 1994). Helms points out that different competencies may be required to effectively counsel non-White clients. It is by no means clear that the same competencies required to deliver effective services to clients for whom racial-group membership is central are equally appropriate for clients for whom other social identities (e.g., gender, age, or religion) are more central. (Helms, 1994, p. 163).

The more narrow view of multiculturalism in counseling psychology has traditionally incorporated the four major ethnic groups in the United States in a *culture specific* orientation. Proponents of this definition believe that non-White groups not only have different sets of values and beliefs from that of the White population, but many have experienced "or been the targets of discrimination and racism. Issues of oppression, racism, and identity have to be acknowledged" in the counseling interaction. (Sue, 1997, p. 178).

Despite the controversy over the definitions of culture and multiculturalism in this field, many training programs do exist. An early, and well-known monograph by Cross, Bazron, Dennis, and Isaacs (1989), identified a program to develop cultural competence in professionals, agencies and systems. The authors talked about a developmental continuum within which cultural competence occurs, that ranged from

cultural destructiveness to cultural proficiency. They identified the various levels in the following manner.

* *Cultural Destructiveness:* This most negative end of the continuum is represented by attitudes, policies and practices that are destructive to cultures and the individuals within the culture. For example: agencies and institutions that promote cultural genocide; The Indian Child Welfare Act; the KKK; Neo Nazis and other racial superiority groups.

* *Cultural Incapacity:* People or groups lack the capacity or will to help non-majority clients or communities. The system remains extremely biased, believes in the racial superiority of the dominant group and assumes a paternal posture towards the disadvantaged. They may exhibit discriminatory hiring practices, apply resources disproportionately, and maintain stereotypes.

* *Cultural Blindness:* Services are provided with the express philosophy of being unbiased. They function with the belief that color or culture make no difference and that all people are the same. It ignores cultural strengths, isolates those who are different, blames victims for their problems, and encourages assimilation.

* *Cultural Pre-Competence:* This level exhibits positive movement. People and agencies are committed to civil rights and desire to deliver quality services. They falsely believe, however, that the accomplishment of one goal or activity fulfills their obligation to minority communities, or they may engage in token hiring practices.

* *Cultural Competence:* People and agencies demonstrate acceptance and respect for difference; they expand their cultural knowledge and resources; engage in continuous self-assessment regarding culture, make a variety of adaptations of service models; seek advice and consultation from ethnic and culturally different communities; provide support for staff to become comfortable working in cross-cultural situations; and commit to policies that enhance services to diverse clientele.

* *Cultural Proficiency:* Agencies hold culture in high esteem; seek to add to the knowledge base by conducting research, developing new therapeutic approaches based on culture; publish and disseminate the results of demonstration projects; hire staff who are specialists in culturally competent practice; and advocate continuously

for cultural competence throughout the system. (Cross et al., 1989, pp. 13-17).

Although the authors emphasize that systems can evaluate their level of competence by comparing their activities to this developmental list, they also go on to identify how cultural competence can be achieved at the policymaking level, the administrative level, and at the practitioner level. As do most education/training programs in counseling psychology (McRae & Johnson, 1991; Sue, 1997), the emphasis on individual development of cultural competence by Cross et al. (1989) focuses on attitudes/self-awareness, knowledge, and skills.

Similar to multicultural education programs in nursing and social work, Sue (1997) reports that "In general, counseling training programs have done better in helping trainees with beliefs and attitudes and knowledge than they have in skills development" (p. 184). A decade earlier Johnson (1987) recognized this by identifying a need to move trainees from "knowing that" cultural differences exist, to "knowing how" to effectively conduct therapy with diverse clients. McRae and Johnson (1991) add, "There is no one training model that seems to encompass all the necessary components in a way that can be evaluated as effective" (p. 132). It is interesting that McRae and Johnson stated the above when the staff of a National Institute of Mental Health training project developed the Development Model of Culture-Centered Training in 1981 (Pedersen & Ivey, 1993). This model provides a framework of competencies that can be used "to evaluate and measure competencies in individual counselors, to identify problems in agencies or organizations, to organize training workshops or develop course materials on multiculturalism, and even prepare to work with a culturally different client in direct service" (p. 23). These competencies do fall into the three areas of awareness, knowledge and skill, which Pedersen and Ivey conceptualize as three developmental stages that flow from one to another in sequence. "The importance of building on the sequence of stages toward informed and intentional multicultural skill is the focus of this three-stage developmental model" (p. 24). The authors emphasize the importance and balance of all three components in effective culture-centered training.

Following this approach, Johnson (1982) developed the Minnesota Multiethnic Counselor Education Curriculum (MMCEC) that attempted to include the development of all three of the components. The program "provided expertise from psychologists representing specific ethnic groups . . ., focused interviews with clients from each ethnic group, and experiential exercises that allowed trainees to practice and apply the knowledge learned" (McRae & Johnson 1991, p. 132). Johnson later went on to develop a graduate course that incorporated the philosophy of the MMCEC.

One well-known model that builds specifically on the skills area is the "triad' model developed by Pedersen in the mid-1970s (Pedersen, 1977). This model has been refined and used extensively in counselor training sessions (McRae & Johnson, 1991; Pedersen & Ivey, 1993; Sue, 1997). "The training model requires a simulated cross-cultural counseling interview between a coached client-anti-counselor team from one culture and a counselor trainee from a different culture" (Pedersen, 1977, p. 480). The anti-counselor takes the part of the client in the role - played interview by representing the problem from the client's cultural viewpoint, and subversively attempts to point out cultural mistakes made by the counselor trainee. This model works on four skill areas which include: articulating the problem, anticipating resistance, diminishing defensiveness, and recovery skills (Pedersen, 1977).

Another approach to multicultural education in counseling psychology is the Systemic Multicultural Curriculum Model by Vazquez (1997). Vazquez decries the one-course approach to multicultural education as insufficient to develop cultural competency. Additionally, by having one faculty member responsible for the multicultural course, others may feel relieved from the responsibility of having to address the issues in class until they are challenged to do so. Vazquez identifies the latter faculty as "multiculturally impaired individuals" (1997, p. 161).

Rather than the one-course approach, Valquez describes the process of developing a systemic approach as the Multicultural Journey (p. 163) which begins with consensus from the faculty on the identity of the program's culture. It moves

then to identifying the goals and aspirations of the program, including the target (implementation of the goals with a specific audience) and scope (the extent of coverage of content in relation to different groups). The context of the multicultural journey is next addressed. This includes the structure of the program and the interpersonal relationships involved. It is here that issues of social power and (in)equality are explored. Valquez states that programs must go through 'dramatic changes' to accomplish this systemic approach (1997, p. 178). The type of changes he speaks of constitute a transformation of the traditional curriculum. Others (Midgette & Meggert, 1991; Reynolds, 1997) agree with this approach. Reynolds (1997) also believes that the single-course approach is inadequate, stating "These courses are not enough. A systems-based approach is necessary in order to create mental health service delivery that effectively meets the needs of traditionally underserved and underrepresented clientele" (pp. 211-212). Although perhaps ideal, an approach such as this would be very difficult to accomplish. It involves significant time, energy, financial resources, and a commitment from the entire faculty to be part of the multicultural training team.

Another common educational/training approach in the counseling psychology literature is the use of particular tools to facilitate learning. Reynolds (1997) writes of the Multicultural Change Intervention Matrix (MCIM), Leong and Kim (1991) introduce the Intercultural Sensitizer (IS), the Culture-Specific Rating Scale (CSRS) is discussed by Nwachuku and Ivey (1991), Ponterotto (1997) developed the Multicultural Competency Checklist, and Ramsey (1994) uses the Personal Cultural Perspective Profile (PCPP) to develop multicultural competence. Although several of these tools are used to develop the three major competency areas of awareness, knowledge, and skills (Leong & Kim, 1991; Ponterotto, 1997; Ramsey, 1994), each is unique in its approach.

Leong and Kim (1991) state that the "basic premise of the Intercultural Sensitizer is to provide the trainee with an active experience from which she or he can learn the important behaviors, norms, values, perceptions, attributions, and customs of another culture" (p.115). They accomplish this by employing a booklet

which can be used as a self-directed learning tool, that contains several critical incidents of cross-cultural interactions. Flanagan (as cited in Leong & Kim, 1991, p.115) defines a critical incident as "any observable human activity sufficiently complete in itself to permit inferences to be made about the person performing the act." "The critical incidents of the IS are selected to represent critical problems and key cultural differences of the target or focal group. . . By discussing a series of incidents and their alternative explanations, trainees begin to learn the beliefs and values of the target cultural group" (Leong & Kim, 1991, p. 115).

Another tool that examines specific cultures is the Culture-Specific Rating Scale (CSRS) (Nwachuku & Ivey, 1991) developed specifically for use with the African-Igbo culture. This 20-item instrument "provides a baseline of how the culture conceptualizes a problem and its mode of solution." . . . "some advantages - the target culture is generating the problem and the theory, rather than an external source" (p. 108). The authors state that this tool could be adapted for use with other cultures as well.

Moving from looking at other cultures to looking more closely at self, the PCPP developed by Ramsey (1994) is a 14 item cultural continua which emphasizes the concept of personal culture in a way that helps counselors recognize personal biases and potential areas of conflict in cross-cultural interactions. Additionally, the purpose of this tool is to help counselors recognize that culture is not external to themselves, and helps to combat cultural group stereotyping (p. 283). The remaining two tools identified above, the Multicultural Competency Checklist (Ponterotto, 1997) and the Multicultural Change Intervention Matrix (Reynolds, 1997) are used to support not only individual, but organizational change. Reynolds believes that multicultural change will not occur or be sustained without organizational commitment, although she cautions that "transforming an academic department into an environment that truly integrates the values and beliefs of multiculturalism is a challenging task" (p. 215). She suggests that a systematic approach that is facilitated by the use of the above tools to "examine the underlying organizational structure of the program and social justice issues" (p. 215) is the best approach to effect lasting

change. It appears that the use of particular teaching tools results in a more limited educational program, one that does not assist a learner in developing all three attributes of cultural competence.

One final educational model identified in the counseling psychology literature is the Multicultural Immersion Experience (Pope-Davis, Breaux, & Liu, 1997). The authors argue that many cross-cultural exercises and simulations used in training may have the opposite effect of reducing prejudice because of the brevity of the experiences. They cite a 1993 study by Bruschke, Gartner, and Seiter that examined student outcomes to a popular classroom simulation game. "They found the simulation increased students' ethnocentrism and dogmatism" and "attributed the outcome to a lack of time to adjust following the culture shock" (Pope-Davis, Breaux, & Liu, 1997, p. 233). As a result of this and other studies, the authors believe that the most valuable experiential exercise in cross-cultural training would be one of longer duration involving direct contact with a targeted culture.

> Such an experience would enhance traditional educational methods, such as role-playing, and make the immediacy of the multicultural experience a reality. Individuals would have the opportunity not only to test and evaluate what they have read and learned about different cultural groups, but to experience how these cultural groups define and experience themselves on a daily basis" (p. 235).

The Multicultural Immersion Experience (MIE) was developed to be part of an academic course and would be completed over a semester. It is designed in three phases. During Phase 1, students identify a cultural group in the university or community that differs from themselves, to become involved with or *immersed* in the activities of that cultural group over the course of the semester. During this phase, students write a short autobiography that includes issues of oppression, race, class, and gender. They then tie this personal history to the group with which they are interacting and begin to explore how the differences in culture may impact the counseling relationship. The immersion experience itself is Phase 2. Students enter this group as an active participant, not an observer. They are required to maintain a

journal during this phase that examines their cognitive and affective experiences and an honest assessment of their feelings of discomfort or anxiety. Classroom discussion is used to explore these feelings and the experiences of the students. Phase 3 includes a class presentation or a roundtable discussion that includes invited members of each cultural group. Debriefing occurs following this exercise. A final assignment for the course includes a reflection paper which allows students to examine how the experience has changed them.

The expectation with this comprehensive model is that students will not only develop increased self-awareness and knowledge of another cultural group, but will also develop effective and lasting cross-cultural skills necessary for cultural competence (Pope-Davis, Breaux, & Liu, 1997).

Despite the years of development of these multiple educational models and programs however, many authors describe the outcomes of these efforts as limited. Within the social work literature, Fong and Gibbs (1995) address the "disparity between the stated goal [of developing cultural competence] and its implementation in training programs and continuing education" (p.1). Authors from the field of clinical psychology were echoing this lament throughout the eighties and nineties (Midgette & Meggert, 1991; Sue, 1981; Sue, Arredondo, & McDavis, 1992) with Quintana and Bernat stating "normative data from counseling psychology programs indicated that most programs are providing training that lead to, at best, multicultural sensitivity, but very few appear to be providing training that prepares practitioners to be multiculturally proficient' (cited in Ponterotto, 1997, p. 113). And in the nursing field Gerrish and Papdopoulos (1999) are concerned that "many educational programmes fall short of promoting the development of transcultural competence" (p.1454), supporting Andrews' (1992) earlier statement,

> A serious conceptual problem exists within nursing in that nurses are expected to know, understand, and meet the health needs of culturally diverse people, without any formal preparation for doing so. Although progress has been made in the integration of cultural concepts into nursing

care, the progress has been disappointingly slow and education for nurses has been sketchy, brief, and nonspecific" (p. 7).

What can the field of occupational therapy learn from these accounts? The following section examines the development of culture and cultural competence within the profession of occupational therapy.

Occupational Therapy and Cultural Competence

Occupational therapy (OT) has lagged behind many other health professions when examining issues of diversity and culture. One somewhat early (and isolated) article by Sanchez (1964) spoke to the relevance of considering cultural values of clients in the development of OT programs. Although there were limited attempts to address these issues found in the literature prior to the civil rights movement of the late sixties and early seventies, some works began to appear at that time (Boles, 1971; Committee on Basic Professional Education, 1969; Paulson, 1975; Utley, 1974). By the latter half of the seventies, language within U.S. society had changed to include the term *minorities.* This was reflected in occupational therapy titles such as "The Involvement of Occupational Therapy with Minority Groups" (Pinto, 1978). The 1980's saw an increased number of articles and reports on diversity in the occupational therapy literature. Articles reflected studies on African American children's performance on standardized tests (Martin, 1986), the role of grandparents in Hispanic families (Raphael, 1988), and an increased awareness of the need for cultural sensitivity (McCree, 1989; Barney, 1989 a & b). In 1987, one publication, *Occupational Therapy in Health Care*, devoted an entire monograph (Vol. 4, Issue I) to cross-cultural analysis of treatment approaches. This monograph was an important addition to the occupational therapy literature as it allowed numerous authors to explore issues of cross-cultural care within a single forum, emphasizing their importance and timeliness.

Changes in occupational therapy education also began to reflect the impact of

diversity. In 1991, multicultural and diversity components were added to the *Essentials and Guidelines for an Accredited Occupational Therapy Educational Program* (American Occupational Therapy Association, 1991). These standards were written to "ensure that all future practitioners will appreciate cultural differences and be aware of the impact of these differences on client-therapist interactions" (Wells & Whiting, 1998, p.2). The new standards became mandates for the inclusion of multicultural and diversity issues in every occupational therapy curriculum in the United States.

The national organization also began to respond. For the first time, minority issues became an independent goal of the American Occupational Therapy Association (AOTA) Strategic Plan (1990-1991). Association policies were developed that addressed the recruitment and retention of minority individuals, inclusion of ethical and cross-cultural concerns and issues in all appropriate AOTA documents and publications, and the use of gender neutral language (Wells & Whiting, 1998). In 1995, the theme of the AOTA Annual Conference was "Diversity: Our Journey Together". All of these events were important in the development of a national examination of diversity, but in my view, the most important and effective structural change was the establishment in 1991 of the Minority Affairs Program (MAP) as part of the Public Relations Department of the American Occupational Therapy Association.

The Minority Affairs Program (MAP) was initially developed to increase the recruitment of minority students to the profession. However, as the needs of the profession changed in response to member and societal shifts, the MAP grew and developed as well. The name of the program was changed to the Multicultural Affairs Program in 1994, and it expanded its purpose.

Over the next several years, multiple efforts were made by the MAP, not only to recruit more diverse members to the organization, but to also "serve as a clearing house for information on issues relating to diversity and multiculturalism" (Wells & Whiting, 1998, p.33). The second director of the program, Shirley Wells, stated that a major goal of the MAP was to provide a sounding board for and to

help meet the needs of the diverse members of the AOTA (personal communication, October 22, 2000). The *OT Practice* article by Wells and Whiting (1998) summarizes the many and varied accomplishments of this program in its seven years of existence. Unfortunately, due to downsizing as a result of budget cuts and structural changes, the Multicultural Affairs Program and its director were terminated in 1998 and some of the tasks of the MAP were distributed among other AOTA staff members and programs.

However, the work of the MAP, coupled with a heightened awareness of the importance of issues related to culture, multiculturalism and diversity resulted in an increased exploration of these issues in the occupational therapy literature. The examination of the impact of culture on one's choice of occupational activities has changed the way occupational therapy practitioners work with consumers. Virtually all of the emerging models of practice that focus on occupational performance address the concept of culture and the importance of evaluating and being sensitive to the cultural context of the client (Christiansen & Baum, 1997; Dunn, Brown & McGuigan, 1994; Kielhofner, 1997; Law, Cooper, Strong, Stewart, Rigby, & Letts, 1996; Schkade & Schultz, 1992). Diversity has been defined in broad terms that include not only racial and ethnic characteristics, but also gender, age, ability, sexual orientation, and class (Wells & Black, 2000), and there has been more interest in the area of cultural competence.

Although Sayles-Folks and People (1990) implored the need for cultural sensitivity training for occupational therapists, the term *cultural competence* was not seen in occupational therapy literature until the early 1990s. Dillard, Andonian, Flores, Lai, MacRae and Shakir (1992) described practice within a diversely populated mental health setting in San Francisco as culturally competent care. The authors stated that the purpose of the article was "to introduce the concept of cultural competence and discuss the importance of culture for occupational therapy in mental health settings" (p. 721). The article was descriptive, defining culturally competent practice and then describing several programs instituted at the institution which reflected that practice. Other descriptive articles such as this addressed minority

women who are disabled (Wells, 1991), Native Americans (DeMars, 1992), older adults from diverse cultures (Barney, 1991), "minority patients" (McCormack, 1987) and Hmong children (Myers,1992), while an entire monograph addressed OT across cultures (Merrill, 1992). Dyck (1991) issued a challenge to the entire profession to consider the importance of multiculturalism and occupational therapy. She stated that although individual therapists had begun to respond to demographic changes within our client population, in order for change to be effective it needed to be a "shared responsibility. Clinicians, educators, researchers, professional bodies and ethnocultural communities all have a role to play in retooling the knowledge base that guides practice, professional education, and the organization of services" (p. 224).

MacDonald and Rowe (1995) responded to Dyck's challenge (1991) within the educational arena by describing a curriculum of "transcultural occupational therapy" that includes curricular infusion of cross-cultural concepts, as well as an individual mentoring program for minority students. A few years later, MacDonald (1998) wrote about an application of Well's (1996) model of multicultural competency at the College of Occupational Therapists in York, Great Britain. Well's model was later refined and described in a book published by the American Occupational Therapy Association (Wells & Black, 2000). Another descriptive account of the use of educational models to establish (multi)cultural competence was offered by Horger and McGruder (1995) at the Annual Occupational Therapy Conference held in Denver, Colorado. And more recently, Bailey (2000) describes an infusion model within an OT educational program to increase students' awareness and appreciation of cultural diversity.

Occupational Therapy Research about Cultural Competence

Descriptive reports have increased in the occupational therapy literature, but reported research on cultural competence or cross-cultural care is limited. Within this meager literature, however, both qualitative and quantitative studies are published,

many of which have been done outside of the United States. Khamisha (1997) surveyed occupational therapists working in Glasgow to determine their cultural awareness when working with clients of Indian subcontinent origins. Therapists self-rated their awareness as quite low (p. 17). A similar study done in the Netherlands by Kinebanian and Stomph (1992), was carried a step farther. The authors used the information from the study to "develop eight educational tools for use within the [OT] schools." In Australia, Westbrook, Skropeta, and Legge (1991) examined the experiences of therapists with ethnic clients and concluded that "There is clearly a need for both educational and continuing education programmes to focus on the difficulties encountered by ethnic clients if they are going to meet their communication and emotional needs" (pp.257-258).

Scott (1997) explored the perceptions of cross-cultural practice by British occupational therapists. Using phenomenological, qualitative inquiry, her findings indicated that "cross-cultural learning and understanding of the client's illness experience are facilitated when therapists adopt a truly non-directive, or client-centered approach to care . . . which requires an attitude of seeing clients as unique persons with the right to live according to their own viewpoint" (p. 93). Whiteford and Wilcock (2000) conducted a 3-year qualitative study with occupational therapy students in Aukland, New Zealand "about their learning, development of skills and competencies for intercultural practice" (p. 325). This article focused only on the concepts of occupation and independence as part of the data gleaned from the study. The participants concluded that independence is a "therapist centered, predominantly Western cultural construct" (p. 331) that must be carefully considered in a culturally sensitive, client centered intervention approach.

Within the United States, Pope-Davis, Prieto, Whitaker, and Pope-Davis (1993) examined the "self-reported multicultural competencies of occupational therapists" (p. 839) using quantitative inquiry. Results suggested that "there is a clear difference in perceived multicultural competencies among those therapists who have a higher level of education, have worked with patients of color, have taken multicultural course work, or have attended multicultural seminars or workshops" (p.

842). The authors also correlated responses with the cultural competencies of awareness, skills, and knowledge identified earlier in this chapter and with a fourth competency of relationship. Working with patients of color most strongly correlated with the competency area of awareness; skills and knowledge were most closely correlated with exposure to multiple kinds of education dealing with multicultural issues; while the competency of relationship showed an absence of any correlation with the variables.

Kim (1996) examined the impact of cross cultural practice on cultural competence in an empirical study similar to that of Pope-Davis et al. (1993). Using the Multicultural Counseling Inventory (Sodowsky, Taffe, Gutkin, & Wise, 1994), her findings "revealed statistically significant correlations between cross-cultural practice and the overall level of multicultural competence" (p. 54). Additionally, further analysis indicated that cross-cultural practice "was a significant factor affecting the levels of Awareness and Knowledge" (p. 55).

The above section indicates only limited research on cultural competence in the occupational therapy literature. However, much abounds in other health related fields. As we examine many of these studies, the basic questions to be answered are; how does one measure cultural competency, its effectiveness, and create approaches to training and education, and what can occupational therapy learn from these studies? These questions will be addressed in the next section.

Research about Cultural Competence in Other Health Related Fields

When I began this paper I was under the impression that there was not much research being done on the topic of cultural competency. I formulated this impression by talking with psychologists and multiculturalists who told me there was little out there. Therefore, I was surprised to find as much in the literature as I did. Perhaps not surprisingly, most of the reported research seems to be happening in the counseling psychology field, with less found in other healthcare professions' literature such as that of nursing, or social work. What was surprising to me, however,

was that the greatest majority of these studies were empirical, quasi-experimental designs with quantitative analyses. There seemed to be few qualitative studies. This will be discussed more thoroughly in the next section.

Because research on cultural competency is quite disparate, it is somewhat difficult to determine how to organize the information in a way that makes it accessible to report and to analyze. Should it be categorized by discipline, by research methodology, by year, by content? After reviewing the literature several times it appears to fall naturally into several content categories. Therefore, I will examine the literature by reviewing the research on a) education and training techniques; b) the efficacy of specific cultural competency attributes; c) culturally competent care; and d) client perception of culturally competent practice.

Some Overarching Thoughts and Ideas in the Literature

Many researchers emphasize how difficult it is to do effective research related to multicultural competence. Sue (1998) believes that because much of the work is related to race relations, "research into these issues will also engender many emotional responses" (p.444). Being emotionally involved in the research certainly influences the manner in which the study is planned, conducted, and reported, and often compromises any hope of objective analysis of the findings...if that is the researcher's goal. Even if a researcher feels that she has no emotional tie to the factors being studied, her unconscious and sometimes unexamined biases and world view will color the findings (Sue & Sundberg, 1996). Helms (1993) reports that White researchers in the area of counseling are the primary gatekeepers of cross-cultural research (p.242). This includes journal editors and dissertation advisors who may provide a "constricted" study of cultural diversity issues because of the particular world view of the White researcher. Cauce, Coronado, and Watson (1998) remind us that "how one designs and conducts research is at once a scientific and sociopolitical process" (p. 305). Some authors wonder if the subjective world of people of color can ever by understood by Whites (Stanfield, 1993). For these

reasons, it is imperative to seek a research approach that will allow for the 'voice' of the person of color to be heard most effectively. It is also vital that researchers carefully evaluate and present their own beliefs, values, and assumptions in order to diminish researcher bias or facilitate the assessment of their work by others. In response to these concerns, Meleis (1996) suggests criteria that (nurse) researchers could use to guide their research and to help determine the rigor and credibility of research studies related to cultural competence.

Education/Training Research

Most health professions academic programs today are guided by broad and non-specific standards developed by their accrediting agencies that require academic content related to diversity and multicultural issues (Darling, Greenwood, & Hansen-Gandy, 1998; Lenburg, 1995; MacDonald, 1998; Monahan, 1997; Trolander, 1997). The literature indicates that academic programs have complied with these standards in a variety of ways, but that there seems to be little systematic approach to teaching multicultural content. (Babyar, Sliwinski, Krasilovsky, Rosen, Thornby, & Masefield, 1996; Andrews, 1992; Kadushin & Egan, 1997). This may be due in part to the fact that there has been insufficient research to articulate and validate effective academic strategies.

Within the plethora of articles that discuss adding multicultural content to health professions academic programs, only a small percentage actually focus on cultural competence and the characteristics or attributes of which it is comprised. As a result, many authors report that insufficient research has been done which examines various aspects of education that promote cultural competence (Allison, Echemendia, Crawford & LaVome Robinson, 1996; Lenburg, 1995; MacPhee, Kreutzer, & Fritz, 1994). The studies that have been reported, however, differ significantly based on discipline.

Social Work

Within the profession of **social work,** mainly anecdotal and descriptive studies or studies that were qualitatively rather than quantitatively analyzed were found in the literature.

Several authors have written about and/or studied particular curricular models or teaching strategies that facilitate cultural competence in social work education. Manoleas (1994) devised a curricular model that identified several outcome objectives for cultural competence. These were based on what he calls the "universal " yet "oversimplified" factors that relate to a person's knowledge, skills, and values. Although this model provides an opportunity for the evaluation of outcomes through research, Manoleas does not suggest how this might occur.

Ronnau (1994) identified five cultural competence teaching strategies and assessed their effectiveness in a descriptive study where students were asked to complete a short survey. From this he identified four major benefits of his program; learned that the majority of the students felt more comfortable asking culturally sensitive questions; and that the students' knowledge about other cultures was increased.

Nakanishi and Rittner (1992) describe and examine a particular classroom approach they named "The Inclusionary Cultural Model." This educational approach "combines teaching traditional sociocultural theories with an experiential classroom component that enables students to move from an emic (Lum, 1986) process of cultural self-definition to an etic (Lum, 1986) perspective of acceptance and respect for the cultural systems of others" (p. 27). Although they did not provide a structured assessment of this model, anecdotal evidence of student transformation is "powerful." By experiencing cultural dissonance and lack of understanding first, "the didactic material about culture and minority status tends to be much more accessible" according to Nakanishi and Rittner (1992, p. 34). The Inclusionary Cultural Model provides students "with an opportunity to examine how culture has influenced their behavior prior to examining how it influences the behavior, values, norms, and

needs of others" (p. 34). This approach to multicultural education appears to have merit, but certainly requires more careful study in order to validate its effectiveness.

Another approach to examining multicultural education is to review the skills and needs of the faculty who are presenting the content. In a qualitative study using grounded theory methods, Singleton (1994) reviewed the comfort of faculty who teach content on racial oppression. Using Strauss' (1987) approach, Singleton chose an exploratory, cross-sectional research design in which she interviewed eleven faculty members from four different urban, east coast schools of social work. The interviews were recorded and follow-up interviews were conducted as necessary, Singleton used open-ended questions to examine the concept of "comfort", and the transcripts of the tapes were coded for analysis.

Her analysis established that "the decision to present or not to present oppression content is not a simple one...The processes through which social work instructors arrive at a decision regarding the presentation of oppression content can be delineated into three distinct paths: avoiding oppression terminology and minimizing oppression content, rejecting all content on oppression, and explicitly including oppression content" (p.16). She suggests further research, both survey and qualitative to further examine this phenomenon.

Nursing

The **nursing** literature seems limited in quantitative research studies but appears to have produced more of these than has social work. Lenburg and her colleagues (1995) report that research on education that promotes cultural competence is "sparse." She identifies articles that talk about research but do not report actual research projects or results, and descriptive reports of model programs or teaching-learning strategies (much like that found in the social work literature), but no actual research studies. Lenburg does indicate that there have been some descriptive studies published in the field of nursing, but that much more needs to be done. Andrews (1992) reports that there is a heavy emphasis on qualitative

research methods in many cross-cultural studies, and because of this nurse researchers often experience funding difficulties. She argues that the "counterproductive debate over quantitative versus qualitative methods should be ended. The choice between qualitative and quantitative research methods depends on the questions asked, and frequently a combination of methods enables the researcher to achieve the optimum results" (p. 13).

Despite these comments, however, one study in the nursing literature that is often cited was done by Pope-Davis, Eliason, and Ottavi (1994). This was an exploratory investigation to determine if nursing students were multiculturally competent. One hundred and twenty undergraduate nursing students were asked to complete the Multicultural Counseling Inventory by Sodowsky, Taffe, Gutkin, and Wise (1994) and a demographic questionnaire that had been developed by the investigators. Results were reported in descriptive statistics, and analyses of variance were completed on the demographic effects. What was discovered was that students with work experience "had significantly more self-perceived multicultural skill and knowledge but not more multicultural awareness. . . than students who have had no work experience"(p.33). This finding has some interesting implications for (nursing) education if it means that students who are somewhat culturally unaware (mis)perceive that they are actually culturally competent. It also raises the question whether someone can actually be culturally competent if she does not have cultural self-awareness. Studies reported earlier in this chapter (Pedersen & Ivey, 1993; Weaver 1999) indicate that that cannot happen.

Another outcome study administered by Alpers and Zoucha (1996) examined cultural competence and cultural confidence in senior nursing students. Using the Cultural Self Efficacy Scale (CSES), two groups of students were evaluated; one group had received diversity course content and one had not. The CSES was developed to measure confidence and perceived competence in a nurse's knowledge and skill to develop culturally appropriate care to three specific ethnic/racial groups (p. 11). Interestingly, the group of students with no prior diversity training perceived themselves to be more confident and culturally

competent than did the 'educated' group. The authors suggest that the latter group of students may have had just enough training to make them realize "that they do not know enough about transcultural nursing, health care beliefs, and practices of specific ethnic groups" (Alpers & Zoucha, 1996, p. 11). This resulted in diminished confidence in their abilities. Alpers and Zoucha summarize that a mere introduction to diversity content is clearly insufficient to develop cultural competence and confidence.

Two additional studies that examined students' self reported cultural competency were conducted more recently by Napholz (1999) and St.Clair and McKenry (1999). In Napholz's study an examination was made of the effects of the addition of an innovative cultural sensitivity intervention to a more traditional course that already incorporated cultural diversity in its content. The self-report instrument used in this case was the Ethnic Competency Skills Assessment (Ho, 1992). Descriptive and multi variant analysis revealed somewhat inconclusive results in this study.

St.Clair and McKenry (1999) had more definitive findings from their study, however. Their study was designed to examine whether two- to three-week international student experiences that called for cultural immersion in a community diverse from their own would effect change "in the students' ethnocentrism, cultural sensitivity, and cultural self-efficacy" (p. 228). The study was completed over 2 years with 10 different groups of students who volunteered to participate in international nursing experiences (N=80).They used a triangulated research design that incorporated both quantitative and qualitative analysis. St. Clair and McKenry examined cultural self-efficacy quantitatively by using Bernal and Froman's (1993) Cultural Self-Efficacy Scale (CSES). Additionally, cultural competence was measured by the type of care the student nurses provided during these experiences, and was assessed qualitatively through participant observation, field note transcriptions, and of examination of journal entries. Scores from the CSES were analyzed using descriptive and multi variate analysis while a qualitative analysis was made of all 80 student journals. The investigators clearly articulated that this was not a qualitative study, but that the analysis of the journals "was completed to further

explain the findings from the quantitative instrument, understand the students' perceptions of the immersion experience, and identify whether a cultural perspective change occurred "(using Mezirow's [1991] perspective transformation theory) (p.231). Later, the authors point out that although the quantitative findings did indicate a difference, it is only with the qualitative analysis that a researcher can learn *what made the difference* in the students. Significant findings from this study indicated that studying cultural diversity in school courses may facilitate "the development of cultural sensitivity and enlighten one about the concept of ethnocentrism, but without living in another culture, students have a limited ability to understand and overcome their own ethnocentrism" (p. 233-234). Students may have initially described themselves as culturally aware and sensitive prior to the experience, ". . . however, they did not become aware of how their ethnocentrism affected their ability to become culturally competent providers until they were immersed in another culture" (p.234).

These findings have important implications for health professions' academic programs that attempt to facilitate cultural competence in their students. One question that St. Clair and McHenry ask is if the same results can happen in culturally diverse communities in the United States, or if they only occur with an international experience.

Psychology

Studies from other disciplines have found evidence to support additional kinds of training/education. MacPhee, Kreutzer, and Fritz (1994), from the **psychology** literature, report on the success of a study called the "Multicultural Curriculum Infusion Project". Faculty volunteers from eight departments of a college agreed to infuse multicultural content into their classes. The study focused on four human development courses that were " sequenced from sophomore to senior level, in terms of increasing emphasis on syntheses of research-based knowledge, theory, and the application to social policy issues" (p. 705). The authors employed

a quasi-experimental design using an attitude pretest and post test that examined racial attitudes and attitudes toward poverty. Additionally, qualitative information was gathered through content analysis of student learning and process evaluations. Results of all of these measures indicate that infusion of multicultural and diversity content had a broad effect on students' attitudes toward outgroups (p. 712).

In summary, the research methods used in studying education and training of culturally competent skills, though limited in volume, are quite varied. Studies range from anecdotal and descriptive reports to grounded theory qualitative analyses and quantitative descriptive or multivariate analysis. There are more quantitative studies in psychology than in social work or occupational therapy. Although nursing researchers have historically engaged in anecdotal, descriptive, and qualitative inquiry, more recently there has been an increase in empirical studies.

Research about Specific Attributes of Cultural Competency

Although there is some consensus that healthcare professionals who wish to become culturally competent must improve their self-awareness, knowledge and skills, there is limited research that examines the development of individual attributes of cultural competence. In 1991, D'Andrea, Daniels and Heck reported on a series of studies conducted with counseling psychology graduate students enrolled in multicultural counseling courses. In each study, the Multicultural Awareness-Knowledge-and Skills Survey (MAKSS) was used to evaluate the participants' perceptions of their development of these attributes. The MAKSS is a self-administered written test consisting of 60 items that are equally divided into three sub scales. Ninety-six students in three different classes from two different educational programs were evaluated. The MAKSS was administered at the beginning and at the end of each class to evaluate differences in outcomes as a result of class structure (one class met 1X/week for 15 weeks, 3 hours per class; the second met 2X/week for 6 weeks, 3 hours per class; and the third class was held in a weekend format with students attending for 5 hours on Fridays, and 9 hours on

Saturdays over 3 weekends). Although there were no significant differences found between the three groups on the pre-test, post-test results indicated a significant difference between the mean ranks of each of the sub scales for all three groups. Results indicated that the courses each positively effected the participants' perceptions of their cultural competence attributes, and the time structure did not effect the results. Although all attribute areas improved, the lowest of the three was that of multicultural skills. (D'Andrea, Daniels & Heck, 1991).

Pope-Davis and Ottavi (1994) examined the association of cultural competency attributes with demographic variables such as race and ethnicity. Using the Multicultural Counseling Inventory by Sodowsky et al. (1994), 220 counselors responded to the 40 items which evaluated skills, knowledge, awareness and relationship. Descriptive statistics and analyses of variance were conducted on the data. Results indicated that ethnicity was the only demographic variable associated with difference in self-reported competencies. "Asian American and Hispanic counselors reported more multicultural counseling knowledge than did White counselors; African American, Asian American and Hispanic counselors reported more competence in multicultural awareness and relationships than did White counselors" (p. 653). Although the meaning of these results is unclear, the authors suggest an ongoing need for continued improvement in the training and practice of all counselors, and specifically "White counselors should be encouraged to work harder to increase and enhance their multicultural knowledge and awareness" (p. 654).

Examination of the attributes of cultural competence is also found in *intercultural competence research.* "By far, the most frequent goal of intercultural competence research has been the identification of variables that could be used as predictors of effective intercultural performance, followed by empirical attempts to understand the correlates of differentially effective adaptations," state Dinges and Baldwin (1996, p106). In a chapter that examines the research on cultural competence over a ten-year span, these authors favor the increase in the complex analysis of quasi-experimental empirical studies.

In a significant literature review, Dinges and Baldwin (1996) examined and

reported on twenty-two separate research studies that had been done on some aspect of intercultural competence between the years 1985 and 1993. The focus of these studies fell within several distinct categories. The investigators examined aspects of intercultural competence, dimensions of intercultural effectiveness, intercultural adjustment, the validity of tools and assessments that measure the above, or they tested previously identified behavioral skills considered to be important in facilitating intercultural effectiveness. The majority of the studies (eighteen out of twenty-two) were quasi-experimental in design. Some of the findings were as follows:

In a study that examined the relationship between intercultural communication competence, knowledge of the host culture, and cross-cultural attitudes, Wiseman, Hammer, and Nishida (1989) found that the degree of ethnocentrism in a person, was the strongest predictor of the culture-specific communication competence, Another study investigated the relationships between previous intercultural experience and self-perceived intercultural competence (Martin, 1987). Not surprisingly, sojourners with the most intercultural experience rated themselves higher in the skills of self-awareness and the ability to facilitate communication. Cui and Awa (1992) examined intercultural effectiveness of individuals, based on interpersonal skills, social interaction, cultural empathy, personality traits, and managerial ability. In a factor analysis which compared these traits to cross-cultural adjustment and job performance, the investigators found that personality traits (including patience, flexibility, empathy and tolerance) accounted for the highest amount of variance (24.4%) whereas cultural empathy (which included previous overseas experience, awareness of cultural differences, empathy for working style, and non judgmental behavior) had the lowest loading (6%) on the factor analysis . Interestingly, this seems to conflict with the findings of Martin's (1987) study above, but this discrepancy may be due to the difference in design and analysis of the two studies. In some agreement with Cui and Awa (1992), Olebe and Koester's earlier (1989) study found that the three most important predictors of intercultural effectiveness were task roles, empathy, and respect.

In summary, it is apparent that there is no general agreement on which "traits" provide the unequivocal basis for cultural or intercultural competence. Dinges and Baldwin (1996) believe that the move away from this kind of research is positive. "This past approach has resulted in composite-trait stereotypes that have contributed little more to the understanding of intercultural competence and has probably been a major nonproductive diversion from more important research" (p.120).

Research about Culturally Competent Care (CCC)

Much of the literature found regarding culturally competent care is written in a generalized, theoretical manner (Chin, 2000), or describes CCC with specific groups of people including African Americans (Giger, 2000), Appalachians (Purnell, 1999), Sexual Minorities (Gonser, 2000), and Psychiatric Nurses (Mahoney & Engebretson, 2000).There were, however, several research studies that examined the results or outcome of culturally competent care with specific groups.

A Canadian study examined CCC with culturally diverse clients with a history of sexual abuse (Austin, Gallop, McCay, Peternelj-Taylor, & Bayer, 1999). Survey research was done with 1, 701 psychiatric nurses from four provinces (Alberta, Saskatchewan, Ontario, and Nova Scotia) to examine their attitudes, knowledge and competencies while working with this client population. The data was qualitatively analyzed by discovering emerging themes and exploring the commonality of themes across provinces. On the question that asked how they rated their ability to provide culturally competent care, four overall themes were identified that were present in all provinces and all nursing groups. These included: *Culture is not the problem* - some nurses felt incompetent working with the diagnostic problem regardless of the clients' culture; *Culture is not an issue* - some nurses did not acknowledge any implications arising out of cultural differences. Interestingly, these nurses rated themselves at the highest level of cultural competence (5 on a scale of 1 to 5); *Culture influences perspective and responses* - many of these

respondents believed that culture was always an issue, that it shapes perceptions and affects clients and treatment regardless of the presenting problem. Many of these nurses rated themselves at the midpoint (3) in cultural competence; and *Culturally specific competence* - some nurses felt more competent with specific cultures than they did with others (Austin et al., 1999, pp 14-17). Overall, only 4.6% of the respondents saw themselves as very competent.

The authors question whether the 5-point Likert question is an accurate assessment of competence, particularly when those who self-assessed at the highest level (5) did not see culture as an issue. They wonder whether "it is possible that the 62.9% of nurses who rated themselves at levels 3 and 4 are so cognizant of the complexities of culturally competent care that they hesitate to claim a higher degree of skill?" (p. 18). Austin and her colleagues summarize the study by stating that the nurses surveyed recognized the importance of culturally competent care, but that they needed more knowledge and understanding of cultural norms and practices in order to proved the kind of care necessary.

Another qualitative (grounded theory) study found similar results concerning the need for increased cultural knowledge about sexual minority males. (Schilder, Kennedy, Goldstone, Ogden, Hogg, & O'Shaughnessy, 2001) Forty-seven HIV positive males were interviewed and participated in focus groups that elicited information about their health care experiences. Participants reported that many health care providers did not recognize the gay, homosexual, or transgendered culture, nor did they attempt to learn more about it. Positive experiences in health care occurred with a few culturally competent providers who could "identify and include the social and sexual identity of their patients, and were aware of inherent cultural values and beliefs" (p. 1657).

Weaver (1999) reported the results of a study of culturally competent helping practices with Native Americans. Sixty-two Native American social workers and social work students completed a survey on knowledge, skills, and values necessary for culturally competent service provision to Native American clients. Survey data was reviewed and categorized into themes which were then classified

into the common attributes of knowledge, skills, and values. Within the area of knowledge, themes included: 1) diversity, 2) history, 3) culture, and 4) contemporary realities. The skill area was broken into two major themes; a) general skills such as communication and problem solving, and b) containment skills which require social workers to refrain from speaking.

Four major themes arose in the values area. These included: a) helper wellness and self-awareness, b) humility and willingness to learn, c) respect, open-mindedness, and a non judgmental attitude, and d) social justice (pp. 220-222). Results of this study help to answer the questions of *what kind of knowledge and skills, and which values* are necessary for culturally competent care for this population.Outcome studies on culturally competent care are limited. I agree with Weaver (1999) when she says that researchers must find a way to measure cultural competence in order to better serve clients from a variety of backgrounds (p. 223).

Research about Client Perceptions of Culturally Competent Providers

Although it is important to assess the effectiveness of cultural competence training and practice as measured by the practitioners, a more important assessment of these behaviors, in my mind, is how the recipients of these actions view their effectiveness. How do clients recognize culturally competent care? Not enough research has been done in this area, but a few investigative studies were found. Most of these, however, focus on the racial and ethnic match of the provider and the client.

A study by Wade and Bernstein (1991) examined the perceptions and satisfaction of Black female clients of their counselor's skills and characteristics, after these counselors had engaged in sensitivity training. They also looked at the attrition rate of these clients. At the end of the first three counseling sessions, each of the 80 Black female clients was asked to complete three instruments to assess their perceptions of counseling. The researchers used multivariate analyses to examine the results which indicated that clients rated those counselors more positively who

had completed the culture sensitivity training. Results also found that these counselors had clients with lower attrition rates. An important finding was that the clients' perceptions were more positively affected by the counselor sensitivity training than by counselor race.

Rogers' (1998) recent study examined the influence of both "race and consultant verbal behavior on perceptions of consultants' competence and multicultural sensitivity." (p.265). She did this by having 154 preservice teachers (research participants) view a videotape of an interview in which the race (African American or White) and verbal behavior (race-sensitive or race-blind) of a consultant and client were completely crossed. The participating preservice teachers rated the consultants on measures of competence and multicultural sensitivity. Rogers performed a 2 x 2 x 2 x 2 x 2 multi variate analysis of the four variables in an effort to "address the methodological shortcomings of previous research by fully crossing all possible racial pairs of the consultant, consultee, and research participant (African American, Caucasian) to understand more completely the impact of race on consultants' behavior. Results indicated that consultants who engaged in race-sensitive verbal behavior were consistently seen by all participants as being more culturally competent and sensitive. Consultants who were able to talk openly about racial issues were seen as being more credible regardless of racial match, although racial match was an influencing factor.

Another empirical study by Gim, Atkinson, and Kim (1991), which also examined the effects of counselor ethnicity and cultural sensitivity on research participant perceptions, however, found that Asian American participants rated a counselor more credible and competent not only when they exhibited culture sensitive behaviors, but when they were also Asian American.

In summary, there are mixed results in these studies. Although most clients/participants rate more highly counselors who exhibit culturally competent skills, the counselors 's racial or ethnic match with the client results in varied responses. As Sue (1998) summarizes, " individual differences in the effects of (therapist/client) match appear to be very important, so that [racial or ethnic] match is neither a

necessary nor a sufficient condition for positive treatment outcomes. In other words, match may be important for some, but not all clients" (p. 444).

Analysis and Discussion of Research Methodologies

What struck me as I began a review of the research on cultural competence, was that the majority of studies were analyzed quantitatively using mainly analysis of variance with ANOVA and MANOVA designs. (Cui & Awa, 1992; Gim, Atkinson, & Kim, 1991; Martin, 1987; Napholz, 1999; Pope-Davis et al., 1994; Rogers, 1998; Wade & Bernstein, 1991; Wiseman, Hammer & Nushida, 1989). The second point I noticed was that almost all of the quantitative studies incorporated self-report survey instruments that lent themselves to quantitative analysis. Only a few reported studies were structured as a qualitative design (Schilder et al., 2001; Singleton, 1994; Weaver, 1999), although a few of the quantitative studies also sought some qualitative data for analysis (MacPhee, Kreutzer, & Fritz, 1994; St. Clair & McKenry, 1999).

Self-Report Scales

Although the survey instruments varied from researcher-designed to standardized, they all measured some attributes of cultural competence. A selected few of the more commonly used scales will be discussed below. *The Behavioral Assessment Scale for Intercultural Communication (BASIC)* self-evaluates: Display of Respect, Interaction Posture, Orientation to Knowledge, Empathy, Task-Related Roles, Relational Roles, Interaction Management, and Tolerance for Ambiguity (Koester & Olebe, 1988). A later study by the authors (Olebe & Koester, 1989) gave preliminary evidence that the BASIC operates similarly for subjects from heterogeneous cultural backgrounds, making it an effective tool to use cross-culturally.

Another assessment tool used commonly in cultural competence research studies is the *Multicultural Counseling Awareness Scale (MCAS), form B.*

(Ponterotto et al., 1994). This is a 45-item self-rating scale developed as a pre-and post-test that utilizes a 7-item Likert-type format. Variables consist of: Knowledge of multi-cultural issues and skills in relating across cultures and awareness of cultural distinctiveness. Knowledge items include the following statements, "I am aware of certain counseling skills, techniques, or approaches that are more likely to transcend culture and be effective with any client" while an item from the awareness section is "I feel that different socioeconomic status backgrounds of counselor and client may serve as an initial barrier to effective cross-cultural counseling" (Pope-Davis & Dings, 1994). A recent analysis by Boyle et al. (1999) indicates that the MCAS:B "is an efficient instrument with satisfactory internal consistency" (p. 208).

Pope-Davis and Dings (1994) performed an empirical comparison of the earlier version of the MCAS and the *Multicultural Counseling Inventory (MCI)* by Sodowsky, Taffe, Gutkin, and Wise (1994). The MCI is a 40-item inventory developed to measure self-reported cultural competency in the four sub scale areas of: multicultural counseling skills, knowledge, awareness, and relationship. An item from the skills subtest is "When working with minority clients, I am able to quickly recognize and recover from cultural mistakes or misunderstandings." A knowledge item includes "When working with minority clients, I apply the sociopolitical history of the clients' respective minority groups to understand them better." In the awareness sub scale one finds the item "I am involved in advocacy efforts against institutional barriers in mental health services for minority clients." And a relationship question is "When working with minority clients, I perceive that my race causes clients to mistrust me" (Pope-Davis & Dings, 1994, p. 96). After an extensive comparative analysis, Pope-Davis and Dings report that the simplest way to explain the difference between the two, is that the MCI focuses on behaviors, whereas the MCAS focuses on beliefs. (p. 100). They go on to say that behaviors seem to be more appropriate for self-report than do beliefs, and therefore, the MCI may in some ways be a more accurate self- assessment.

Most of the self-report scales used in these studies have multiple questions that attempt to identify and assess the attributes of cultural competency. Many

provide an opportunity to grade the responses through the use of Likert scales. Several authors (Cauce, Coronado, & Watson, 1998; Pope-Davis et al., 1994, p. 33) identified some of the limitations of self-report measures as: participants selecting responses that they thought were more socially desirable rather than being entirely honest, participants assessing anticipated rather than actual behaviors, and participants interpreting items differently than intended. Sue (1996) identified four separate limitations as "(a) The instruments may measure "anticipated" rather than actual behaviors or attitudes correlated with MCT [multicultural counseling and therapy] competence, (b) they are prone to social desirability, (c) the conceptual foundations of the instrument may not match that of the training program, and (d) we cannot be certain as to what the instruments truly measure" (p. 281).

Although these limitations are important considerations, another concern that I have with self-report surveys is that they often do not allow the respondent to answer the questions in her own voice and words, maybe because that kind of data is too difficult to quantify. Therefore, these so called "self-report" surveys do not actually seek a respondent's personal thoughts and ideas about cultural competency; rather, they ask a research participant to respond to the thoughts and ideas (regarding cultural competent attributes) of the authors of the survey. I believe this is a significant missing component in the current research. What might we discover if we examine cultural competency in another way, using qualitative analysis for fresh comprehension?

A Look at Qualitative Research and What it Offers

What is it that qualitative research might accomplish that differs from quantitative? What kinds of questions can be answered with a qualitative approach? And how could this apply to research on cultural competence? Before answering these questions about what qualitative research *does*, one has to understand what qualitative research *is*.

According to Creswell (1998), "Qualitative research is an inquiry process of

understanding based on distinct methodological traditions of inquiry that explore a social or human problem. The researcher builds a complex, holistic picture, analyzes words, reports detailed views of informants, and conducts the study in a natural setting" (p.15). The components that make up qualitative inquiry identified in the above statement, define what differentiate this approach from quantitative analysis. While both attempt to understand social or human problems, quantitative methodologies tend to look at the "why" of it, while a qualitative approach looks at the "what" or "how." Quantitative questions look for comparison of groups and studies the variance of different factors, as the majority of the studies reported in this paper do, while the questions in a qualitative study result in rich descriptions of what is going on and how it is understood by the actors. Creswell (1998, p.15) suggests that "quantitative researchers work with a few variables and many cases, whereas qualitative researchers rely on a few cases and many variables. "

The advantages of a quantitative approach is that one can "measure the reactions of a great many people to a limited set of questions, thus facilitating comparison and statistical aggregation of the data" (Patton, 1990, p.14). This approach also allows for greater generalization of the results. My concerns with this, however, and with the majority of the studies discussed in this paper, are that (a) the reactions of the respondents to the survey questions, are just that - reactions to an external stimulus, and (b) the words, ideas, and concepts in those surveys do not come from the respondents themselves, and in most cases it disallows them an opportunity to express themselves in their own voices. One doesn't learn how the respondents understand or personally view the phenomena. The researcher only gets a general view of how the participants respond to someone else's questions - questions which may not even be the most relevant ones to them, the participants.. In contrast, a qualitative study may be more exploratory in nature, giving a more in depth perception of the phenomenon (Creswell, 1998). Silverman (in Coffey & Atkinson, 1996, p.5) states that qualitative analysis is distinct in that it is "centrally concerned with avoiding a 'social problem' perspective by asking how principals attach meanings to their activities and 'problems.' "

This is what is so compelling about qualitative analysis. It explores and finds meaning related to a topic, rather than just describing and comparing as is done in quantitative studies. Maxwell (1996) states that meaning is central in interpretive approaches to social science research, and the importance of a qualitative study is that "you are interested not only in the physical events and behavior that is taking place, but also in how the participants in your study make sense of this and how their understandings influence their behavior" (p.17). Trying to determine how occupational therapy students 'make sense' of the concept of cultural competence is a compelling idea for me.

The 'face-to-face' process through personal interviews, typical of qualitative studies "adds depth, detail, and meaning at a very personal level of experience" (Patton, 1990, p. 18). At its best it "permit(s) one to understand the world as reported by the respondents" and "enable(s) the researcher to understand and capture the points of view of other people without predetermining those points of view through prior selection of questionnaire categories" (p. 24). This is another strength of qualitative analysis and is what has been missing heretofore in the studies of cultural competence. Others have compiled lists of attributes and asked people to respond to them, but few studies have asked what cultural competence means in a way that allows the respondent to discuss her own perspective.

At its worst, this face-to-face quality of qualitative inquiry sometimes is the basis for its most common problems. Glesne and Peshkin (1992) identify the issues that 'entwined lives' can raise. These personal interactions "necessitate the discussion of rapport, subjectivity, and certain ethical issues" (p.xi). It changes how we approach and refer to the people we want to learn about. It causes the researcher to question and reflect on her own beliefs and biases, and how those may influence the interaction between the researcher and the researched. In many ways, the face-to-face interaction not only personalizes the qualitative study, it also complicates it.

Another unique feature of qualitative inquiry is that it occurs in the participant's *natural* environment. By interviewing and/or observing people within their own

environmental context one has the opportunity to examine a 'lived life.' Creswell (1998) believes that if "participants are removed from their setting, it leads to contrived findings that are out of context" (p. 17). A questionnaire, or survey, such as those used in the quantitative studies reported above, generally does not consider the context of the respondent's life. Responses are static, lifeless, and easily objectified and enumerated. There is no opportunity to question the respondent further in order to clarify a point or embellish an answer. Nor can the researcher evaluate the influence of the respondent's environmental context on her responses and the respondent cannot respond in her own voice! Although more easily statistically analyzed, quantitative data lack the richness and depth of qualitative data.

The data one derives from a qualitative study, regardless of the type or tradition (Creswell, 1998) of research design, are *words*, not *numbers*. "Words, especially organized into incidents or stories, have a concrete, vivid, meaningful flavor that often proves far more convincing to a reader - another researcher, a policy maker, a practitioner - than pages of summarized numbers" (Miles & Huberman, 1994, p.1). However, the richness of the data is another source of the complexity inherent in qualitative inquiry. The role of the qualitative researcher is to make sense of the data and the ways they intersect, to "interpret how the various participants in a social setting construct the world around them" (Glesne & Peshkin, 1992, p.6). "Qualitative researchers avoid simplifying social phenomena and instead explore the range of behavior and expand their understanding of the resulting interactions. Throughout the research process, they assume that social interaction is complex and that they will uncover some of that complexity" (p.7). Analyzing qualitative data is an open, emergent process which allows for discovery of new ideas and perspectives. It allows for the negotiation of a shared understanding between the researcher and the research subject. Because of this openness and lack of standardization (which is more readily seen in a quantitative study), it may also lead to ambiguity (Glesne & Peshkin, 1992). It takes a certain kind of researcher to be able to tolerate the 'messiness' of qualitative data and analysis.

"In qualitative inquiry, *the researcher is the instrument*. Validity in qualitative methods, therefore, hinges to a great extent on the skills, competence, and rigor of the person doing fieldwork" (Patton, 1990, p. 14). A qualitative researcher must see her role as an "active learner who can tell the story from the participants' view rather than as an "expert" who passes judgment on participants" (Creswell, 1998, p. 18). She must be committed to spending time with the participants, and be willing to engage in hard and rigorous analysis to effectively make sense of the data.

Although some researchers believe that the research question determines the research design, Glesne and Peshkin (1992) believe that it is more related to the personality of the researcher and that "people tend to adhere to the methodology that is most consonant with their socialized worldview" (p.9). They cite Schwandt who states that, "We conduct inquiry via a particular paradigm because it embodies assumptions about the world that we believe and values that we hold, and because we hold those assumptions and values we conduct inquiry according to the precepts of that paradigm" (Glesne & Peshkin, 1992, p. 9).

As a researcher, my personality and world view seem more compatible with qualitative inquiry. Additionally, the research question that I am examining, how do occupational therapy students experience and understand the concepts of cultural competence and culturally competent care, is better addressed using a qualitative methodology.

Conclusion

Cultural competence is a concept that is increasingly written about within the literature of the various health professions. This literature review has examined the meaning and attributes of cultural competence from the professions of nursing, social work, counseling psychology and occupational therapy. It has also reviewed educational models presented by the professions, and the outcome research that examines the effectiveness of those models. Although health professions education programs teach about culture and diversity, research that examines

aspects of cultural competence and culturally competent care is effectively limited. What is most commonly reported are quasi-experimental, empirical designs that examine research participants' (students or practitioners) views of cultural competent attributes through the use of self-report surveys. One premise of this chapter is that qualitative analysis would be a more effective approach to examine the meaning of cultural competence and culturally competent care to the occupational therapy student. As we begin to understand how students think about this concept, educators can more effectively teach about it in our classrooms and clinics. In the final analysis, those who will benefit from this greater understanding will be the clients and the practitioners who work with them.

Therefore, the purpose of this study is to examine (through phenomenological methodology) how occupational therapy students "voice" their understanding, definition, and meaning of the concepts of cultural competence and culturally competent care in their last year of occupational therapy study.

CHAPTER 3

CONCEPTUAL FRAMEWORK & METHODOLOGY

Conceptual Framework of the Model

This dissertation study will examine how occupational therapy students "voice" their understanding, definition, and interpretation of their experiences with culturally competent interactions and care. In the literature, cultural competence has been defined as "an ability by health care providers and health care organizations to understand and respond effectively to the cultural and linguistic needs brought by patients to the health care encounter" (Cross Cultural Health Care Center, 1995). The intent of this study is to listen carefully to the specific language and words used by students in order to understand the essential nature of cultural competence to the participants at the end of their academic experiences as occupational therapy students.

As the researcher, I am particularly interested in hearing the students' own words on the subject - hearing their voices. The term *voice* is defined as "the power of speaking or the right of expression" (Merriam-Webster, 1995, p.586). Gilligan (1993) defines *voice* as follows:

> . . . I mean something like what people mean when they speak of the core of the self. Voice is natural and also cultural. It is composed of breath and sound, words, rhythm, and language. (p.xvi).

Listening carefully to the "breath and sound, words, rhythm, and language" participants use as they describe their experiences is an intentional and important aspect of this study. Many other examinations of cultural competence in the literature (Cui & Awa, 1992; Martin, 1987; Rogers, 1998) use self-report surveys on which participants respond to language (about cultural competence) chosen by someone else (the authors of the surveys). Within these surveys, participants rarely have the opportunity to talk about cultural competence in their own words. Because voice

reflects one's cultural position in society (Gilligan, 1993), and because the focus of the study is on cultural competence, this researcher believes that it is important to examine the manner in which the respondents give voice to their experiences with, and understand the meaning of the phenomena of cultural competence and culturally competent care.

Phenomenology and Voice

Phenomenological research is one tradition or approach found within the broader category of qualitative inquiry (Creswell, 1998). Although qualitative and quantitative research both are methods of inquiry that are used to explore social or human problems, they differ in several important ways. Quantitative research is deductive, while qualitative is inductive; quantitative research can be used with large numbers of subjects selected randomly, and therefore the results are generalizeable, whereas qualitative research usually involves a much smaller number of participants, gaining insight into their personal responses to an issue or event; quantitative analysis involves the use of statistics, reporting results in numerical form, while qualitative analysis uses words as data, reporting results in long narratives; quantitative research is objective and sometimes sterile, with the researcher often not having to interact with his or her subjects in any personal way, whereas qualitative research is much more subjective, where the researcher usually interacts with the research participants in a face-to-face manner in the participant's natural environment (Bailey, 1997; Creswell 1994, 1998).

If a researcher has a question or topic that she knows will require personal interaction with participants in their own (natural) environment, then she will most often choose a qualitative method of inquiry. The question then becomes, which method is appropriate for the study? There are many to choose from. Creswell (1998) identifies five separate traditions of qualitative analysis, and thoroughly describes their separate and distinct methodologies. There are many similarities between the five approaches; biography, grounded theory, phenomenology, ethnography, and

the case study, but the differences between them determine the choice of inquiry. As one reviews Creswell's comparative chart (1998, p. 65) in his appendix I, one sees that, although phenomenology uses interviews as data collection as do the majority of the other research traditions, the focus, the discipline origin, the data analysis and the narrative form differ from those of the other methodological approaches.

Phenomenology is the only approach in this group that is used to "understand the essence of experiences about a phenomenon" (Creswell, 1998, p. 65) by examining the meaning of that experience for each individual interviewed. Cohen, Kahn, and Steeves (2000) state that "the . . . phenomenologist will study how people interpret their lives and make meaning of what they experience" (p. 5). They and others identify phenomenology as the "study of lived experience" (Cohen, et al., 2000, p. 1; van Manen,1990). Language is an important aspect of "voice" and phenomenologists believe language is significant. "The meaning of words is important to think about because language is a primary way we express our meanings" (Cohen et al., 2000, p. 10). By carefully listening to a research participant's narrative story regarding the phenomenon in question, the researcher truly has the opportunity to hear her "voice" as described by Gilligan (1993).

Phenomenology is derived from the discipline of philosophy, and the philosopher Hegel (as reported in Moustakas, 1994) referred to it as "knowledge as it appears to consciousness, the science of describing what one perceives, senses, and knows in one's immediate awareness and experience" (p. 26). This definition seems to underscore the same depth of understanding as Gilligan's "core of the self" (1993, p. xvi).

Moustakas (1994) identifies several principles, processes and methods identified with phenomenology. These include, but are not limited to the following statements.

Phenomenology:

* seeks meanings from appearances of things and arrives at essences

* is concerned with wholeness
* is committed to descriptions of experiences, not explanations or analyses
* is rooted in questions that give a direction and focus to meaning (58 & 59).

These statements resonate with what I am seeking in my doctoral research. Because I am interested in how occupational therapy students understand and make meaning of their experiences with culturally competent interactions and culturally competent care, a phenomenological approach seems an excellent methodological match for my study.

Methodology

Preparation for the Study

Writing the Prospectus/Proposal

For the purposes of this paper, the terms *proposal* and *prospectus* will be used interchangeably. The prospectus for the study, along with a consent form (Appendix A) designed to meet the requirements of federal guidelines, was written and sent to the University's Institutional Review Board (IRB). After a second rewrite to more closely meet institutional guidelines, it was accepted by the review board. The frustration of having to rewrite gave me a greater understanding of Seidman's (1991) concept of "rite of passage."

The Pilot Study

I decided to carry out an initial pilot study in order to familiarize myself with and practice doing phenomenological research. I also used the responses and feedback from the pilot to revise my protocol and interview questions. Glesne and Peshkin (1992) state, "A pilot study can test many aspects of your proposed research. It does so under circumstances that don't count, so that when they do count, you can

put your best foot forward" (p.30). This was essentially my aim in doing a pilot project.

Determining the Sites and Participants

Phenomenological research is the study of a person's lived experience (Creswell, 1998; vanManen, 1990). According to Creswell, its purpose is "to determine what an experience means for the persons who have had the experience and are able to provide a comprehensive description of it" (p. 53). Each person interviewed has to have experienced the phenomenon in order to be part of the study. Therefore, the researcher must identify the phenomenon or experience that she wants to study, and then select research participants who have had that experience. Patton (1990) describes this as *purposeful sampling* . He states, " The logic and power of purposeful sampling lies in selecting *information-rich cases* [author's italics] for study in depth" (p. 169). Because each occupational therapy education program must address issues of culture and diversity in their curriculum, I assumed that each student would know something about cultural competence. I also assumed that students from an urban area, where there is usually a greater percentage of people from diverse groups, would have had experiences that they could identify as being culturally competent or culturally incompetent. Students in their final year of occupational therapy study also have had multiple fieldwork experiences where they may have observed or been part of culturally competent care.

The goal for the ***pilot study*** was to test out the methodology rather than the inquiry question. I had not carried out a phenomenology study in any of my academic courses on qualitative research, and I wanted the practice with somewhat limited data before attempting to do the dissertation study analysis. Given this rationale, coupled with the external time constraints I was working under, I decided that I would work with a small *sample of convenience* selected from the class of second-year students from my own program. I was aware of the power issues that

Seidman (1991) warned about, but I believed that because I was more interested in the process than the content, the interviews would not be compromised by my relationship with the students. Additionally, I had not taught these students a class in the last two semesters, so there was not an ongoing teacher/student relationship. Three students signed consent forms and volunteered for the pilot study. After a mix-up with a transcriptionist who became ill, one audio tape of one of these interviews was never returned, which limited my study to two participants. One participant is a 26-year-old man born in India who immigrated to this country when he was eight years old. The second participant is a 51-year-old White woman.

For the ***dissertation study***, I chose not to interview students from the program that I direct. Glesne and Peshkin (1992) warn that it is "not advisable to conduct your study in your own backyard - within your own institution or agency, or among friends or colleagues" (p.21). They go on to cite the confusion and sometimes the political and ethical dilemmas that may arise from trying to assume a new role (objective researcher) in a setting within which you already have established relationships and multiple familiar roles. Seidman (1991) warns about the "perils of easy access" and particularly speaks about the difficulty of a faculty member obtaining full responses from students that she teaches. He believes that the power differential would cause students to more closely monitor their replies.

Participants

Using a criterion sample (Creswell, 1998), occupational therapy students in their last year of academic study in two urban universities in the Northeast section of the United States were recruited to participate in the study. The universities were selected based on their strong academic reputations, the required multicultural content in their curricula, and their geographical proximity to the researcher.

A key faculty member from one university and a department chair from the other were contacted to seek permission for students' participation in the study. Upon receipt of this permission, a cover letter (Appendix B) and consent form

(Appendix A) were sent to all second year master's level occupational therapy students from both programs via the faculty. Twelve students were randomly selected from those who responded. The number twelve was chosen because Dukes (as cited in Creswell, 1998) recommends studying three to ten subjects in a phenomenological study and Creswell agrees that ten is a reasonable sample size. As he points out, "The important point is to describe the meaning of a small number of individuals who have experienced the phenomenon" (Creswell, 1998, p. 122). I chose twelve in case of attrition. Scheduling the interviews was done via email and telephone at which time I also described the study and asked the students to think about the concept of cultural competence and their experience with it.

All participants (100%) identified themselves as Caucasian or White, although one woman specified that she was Jewish/Caucasian. All are female and they range in age from 23 to 39 years, with a mean age of 27.7 and a median age of 25.5. Eight participants are in their twenties and four are in their thirties. One hundred percent of the participants have spent time with people who are culturally different from themselves, and four (33%) have lived in a country outside the United States. All participants indicated that they have studied multiculturalism/diversity in college in the following ways:

Type	Number*	%
Specific Course	**5**	**42**
Modules	**4**	**33**
Lectures	**3**	**25**
Guest Speakers	**5**	**42**
Infusion through curriculum	**8**	**67**
Field Visits	**2**	**17**

* several participants indicated more than one category.

Data Collection

After making arrangements to meet the twelve students at their university at a time and place convenient to them, an in-depth, semi-structured interview (Appendix B) was completed during the last semester of their academic program. There are numerous ways to conduct phenomenological research, although every author in the literature agrees that the majority of the data collection is through interviewing. Creswell (1998) states that the researcher should do "long interviews with up to 10 people" (p. 65). Others agree that a "long" interview is the preferred methodology (Moustakas 1994) in order to elicit the personal narratives related to the phenomenon in question. The purpose of the interview is that of learning about the meaning of the lived experience of each participant, how each person understands and perceives the phenomenon they have undergone.

Given the information from the literature above, I chose to do one long interview with each student participant. Interviews were from 60 minutes to 75 minutes in length. With permission from each participant, the interviews were audiotaped to ensure accuracy and later transcribed for analysis. Additionally, participants were asked to fill out a short questionnaire that gathered demographic data such as age, gender, ethnicity, and experience with diverse groups of people (Appendix C). The term culture was defined on the questionnaire so that each participant would have the same understanding of the term. The questionnaire also asked if and in what ways they had studied multiculturalism/diversity in college. This data provided pertinent information that may not be gleaned from the interviews.

Descriptive and reflective field notes (Glesne & Peshkin, 1992) were taken during and following each interview and included specific observations of the participant, the setting and the process. These notes and the data used from the questionnaires are included as a means of triangulation to increase the "trustworthiness" of the data and analysis (Glesne & Peshkin, p. 24).

Method of Analysis

The goal of analysis is "a thick description that accurately captures and communicates the meaning of the lived experience for the informants being studied. A thick description is one that captures the experience from the perspective of the informant in its fullest and richest complexity" (Cohen et al., 2000. p. 72; Geertz, 1973).

In order to accomplish this goal, the researcher must follow several clearly defined steps as part of the analysis. According to Creswell (1998) and Moustakas (1994), most phenomenologists follow the same procedure for analysis.. Using the complete transcription of each participant, these steps include the following:

1. Listing and preliminary grouping - *horizonalization*
2. *Reduction and elimination*
3. *Clustering and thematizing*
4. Constructing an *individual textual description* of the experience for each participant
5. Constructing an *individual structural description* of the experience for each participant
6. Constructing a *composite textual description* of the experience
7. Developing a *textual-structural synthesis* of the meanings and essences of the experience, representing the group as a whole

Horizonalization

The first step of phenomenological data analysis occurs by reading the transcripts several times, a process sometimes referred to as "immersing oneself in the data" (Cohen, et al. 2000, p. 76). This is important in order for the researcher to understand and identify the essential characteristics of the data from each interviewee. In **horizonalization,** the researcher makes herself receptive to the data in a way that recognizes that each statement holds equal value. Therefore, all

statements relevant to the question/experience are identified as meaningful.

Reduction and Elimination

The **reduction and elimination** phase is completed to determine the invariant constituents. "The invariant horizons point to the unique qualities of an experience, those that stand out" (Moustakas 1994, p. 128). He identifies two requirements that help to evaluate each horizonalized expression. The researcher must ask:

1. "Does it contain a moment of the experience that is a necessary and sufficient constituent for understanding it?" and
2. "Is it possible to abstract and label it? If so, it is a horizon of the experience" (p. 121).

If a statement does not meet these two requirements, it is eliminated during this phase. Additionally, overlapping, repetitive, and vague expressions are dropped at this time. The horizons, or statements that remain, are considered "the invariant constituents of the experience" (Moustakas, 1994, p. 121).

Clustering and Thematizing

Clustering and thematizing is the next step in reducing and organizing the data. The "thematic portrayals of the experience" represent "distinctive processes inherent" in a culturally competent interaction (Moustakas, 1994, pp. 131-132). Seidman (1991) included a three-page section in his book on "Making Thematic Connections" (pp. 99-101). Within this section he talks about organizing excerpts of the transcripted data into categories. "The researcher then searches for patterns and connections among the excerpts within those categories and for connections between the various categories that might be called themes" (p. 99).

Individual Textural Description

Although I found myself wanting to move directly to a comparison analysis, in an effort to stay true to the process outlined by Moustakas (1994), I turned to the next step of phenomenological process, constructing an **individual textural description** of the experience for each participant from the themes that had been identified. Creswell (1998) identifies this step as an opportunity to describe what was experienced.

Individual Structural Description

Following the step above, I completed an **individual structural description** of the experience for each participant. This step describes how the phenomenon was experienced by the participant (Creswell, 1998). It "provides a vivid account of the underlying dynamics of the experience, the themes and qualities that account for "how" feelings and thoughts connected to [cultural competency] are aroused, what conditions evoke [culturally competent interactions]" (Moustakas, 1994, p. 135). This is the place within the analysis where the researcher uses "imaginative variation, reflection, and analysis beyond the appearance and into the real meanings or essences of the experience" (Copen as quoted in Moustakas, 1994, p. 135). It is where the researcher can plumb the depths of the meaning of this experience for the participant.

Composite Textural and Structural Descriptions

From the total group of individual textural descriptions, I then developed a **composite textural description.** This is where I examined the meanings and themes of each participant and combined them to depict the experiences of the group as a whole. Likewise, I followed this step by developing a **composite structural description.** This description "is a way of understanding *how* the co-

researchers [participants] as a group experience *what* they experience" (Moustakas, 1994, p. 142).

Textural-Structural Synthesis

The final stage of analysis outlined by Moustakas (1994) is the development of the **textual-structural synthesis.** I integrated the composite descriptions above to develop a synthesis of the meanings and essence of the experience, reflecting the voices of the group as a whole. Examples of this process and the analysis of the findings are included in the next chapter.

Critique of the Research Methodology

Although this critique is not chronologically placed within the sequence of the dissertation study, I chose to incorporate it here in chapter three because it speaks specifically of the methodology and my experience with it.

Phenomenology appeared to be the appropriate research approach to use for this study given the fact that I wanted to examine students' perceptions and experiences of cultural competence by listening closely to their 'voices' or words. I initially knew little about phenomenology, but after reading about it in several books (Cohen et al. 2000; Creswell, 1998; Moustakas, 1994; Seidman, 1991; van Manen, 1990) I chose Moustakas' guidelines because they seemed more clearly defined than anything else I had read. Phenomenological methodology arose from philosophical thought and I found much of the literature about it quite dense and incomprehensible.

A positive aspect about analyzing the data with this method, was that it accomplished the goal of being true to the words of the participants. By going through the multiple steps of Moustakas' outline, I was made aware of constantly grounding my findings in the data, of not imposing my own interpretations beyond what the words of the participants indicated. I found myself often returning to the

transcripted words from the interviews, assuring that I was representing the ideas and perceptions of the participants as accurately as possible. I was also aware of trying to maintain the *epoche* of phenomenology. Moustakas (1994) describes this as "setting aside prejudgments and [maintaining] an unbiased, receptive presence" (p. 180) with the participants and the data. This is done in an effort to "enter the world of the unique individual being studied. The aim is to try to see the world from another's point of view" (Finlay, 1999, p. 302).

I found this difficult at times, and wondered how much my own knowledge about cultural competence, and my hopes for and expectations of the student responses influenced my interviews and my data analysis. Although I believe it is impossible to maintain a totally objective and non influential stance during qualitative research, this methodology made me aware of the importance of trying to do just that. That awareness resulted in a dynamic interaction between the process of data analysis, and my self-reflection of trying to maintain an objective and impartial stance. It sometimes felt as though I was walking a tightrope. Each time I became aware of dipping into my own assumptions, my balance was compromised, and I became acutely aware of trying to regain the ability to move forward without peril. For example, as I was examining the concept of awareness, I found myself moving some of the phrases from the participants' transcripts into the wrong cluster (of self-awareness) during the thematic analysis. When I realized I was manipulating the data based on my expectations and what I knew from the literature, I made a concerted effort to begin again with a more open awareness that would allow the data to fall into more natural clusters rather than those that I was looking for.

Additionally, I do believe that Moustakas' phenomenology led to a true examination of how students perceive and experience cultural competence and culturally competent care. Because I was not imposing my own words and ideas on the participants, but listening well and helping them develop their ideas by using follow up questions, I was able to draw out their perceptions in their own words and expressions. The analytic process caused me to continually return to their words in an attempt to stay true to their meaning. As a result, I believe I found a deeper

understanding of their experience through this process.

However, I found the methodology quite tedious at times. I was determined to follow Moustakas' (1994) guidelines, and forced myself to perform each step of analysis as outlined. It was difficult to differentiate between textural and structural descriptions sometimes, and I found that separating the analysis into those categories was rather arbitrary and somewhat limiting. Although doing the thematic analysis was enjoyable and exciting, reminding me of a grounded theory approach, constantly remembering to separate the words and what they said (textural analysis) from the meaning of those words (structural analysis) seemed to limit any kind of creative thematizing. Perhaps that is the purpose of this approach, and is what keeps the analysis so grounded in the words of the participants. This way the "essence" of the phenomena is truly derived from them and not from the researcher.

I also realized that the purpose of this methodology is not to develop theory as in grounded theory research, but rather to define what exists from the minds and perceptions of the participants. Phenomenology examines and reports the meaning of the lived experience (van Manen, 1990) of a group of people rather than attempting to create new ideas based on the analysis of people's thoughts or experiences. Because it was important to me to listen to the voices and words of the students as they articulated their understanding of cultural competence and culturally competent care, this approach better met my goals than another such as grounded theory.

Is this, then, a research methodology that is effective for occupational therapy research? In general, I would say yes. Using phenomenology to examine the meaning and essence of an aspect of life matches the goal of the occupational therapist who is interested in understanding the meaning clients ascribe to life activities and roles. The study of occupation is an analysis of the person, his or her environment and the activities (occupations) that are meaningful to that person (Christiansen & Baum, 1997; Law et al., 1996). Phenomenology offers a research approach that can help occupational therapists examine the personal meaning inherent in the activities that people choose to engage in.

Finlay (1999) summarized occupational therapy research where the investigators used a phenomenological approach. She recognizes it as a viable research methodology for the health professions because it helps to "articulate important messages about individuals' unique experiences" (p. 300). Finlay also discusses the problems with using phenomenology, however. After citing prominent occupational therapy researchers who have completed phenomenological research studies, Finlay states,

> While the authors cited above show an easy familiarity in terms of applying phenomenological methodology, they rarely offer sufficient details of their actual method. Then there are other authors who do not demonstrate this familiarity in the first place. They assert that they are applying phenomenology whereas in reality they are simply using a generalized qualitative approach (p. 300).

I have also recognized this lack of clarity in articles that I have read and reviewed for a national journal of occupational therapy. The complexity of the process contributes to the difficulty in describing the methodology. I have experienced this myself as I carefully attempted to follow Moustakas' guidelines. I found myself wanting to skip some steps in his process when they became repetitious and somewhat tedious, but forced myself to continue as I wanted to stay true to the methodology. As a result of the repetition, the description of the process became somewhat redundant as well. It is, therefore, understandable that researchers do not carefully describe in detail all of the steps of phenomenological methodology.

Although I believe phenomenology as a method has merit for occupational therapy and other health fields' research, the complexity of Moustakas' methods is a barrier to the process. Could one simplify the process and still examine the essence of life's experiences of study participants? If this were possible, would the researcher accurately be using a phenomenological approach, or would the process became a more generalized qualitative approach as stated above? I do value the process I followed for this study, but I tend to agree with Finlay's (1999) conclusion.

"With all its depth, richness and unquantifiable forms, phenomenology can never be an easy research option" (p. 305).

CHAPTER 4

PRESENTATION OF DATA

Data analysis was completed as described in chapter three. I carefully read each transcript and identified each salient statement (horizonalization). I then went through each of the statements and eliminated those that did not apply to the research question (reduction). The remaining statements were then chunked into similar categories, which were then examined for underlying themes. Individual textual descriptions were constructed from the themes identified in each transcript, and further analysis was done to construct individual structural descriptions for each participant's experience. As suggested by Moustakas (1994, p. 184), this chapter will provide (two) examples each of individual textural descriptions and individual structural descriptions. The majority of the chapter will focus on the thematic analysis that I engaged in to develop the composite textural description. This will be followed by the composite structural description and the synthesis of the "meanings and essences of the experience" (p. 184).

Individual Textural Descriptions

An individual textural description of the nature and focus of cultural competence and culturally competent care was constructed from the themes and horizons of each participant's experience (Moustakas, 1994). These descriptions identify <u>what</u> the person's experience was. The following selections present the experiences of L.F. and J.M.

L.F. Participant #1
Individual Textural Description

LF describes her perception of the phenomenon of cultural competence and

what characteristics are essential to it. She views it as a linear, developmental process.

> *I think cultural sensitivity leads to more knowledge and then leads to cultural competence.*

She later added to this formula that cultural competence results in a deeper understanding between people and groups who are different from one another than does sensitivity.

For LF, the most important characteristic of cultural competence is sensitivity, which holds a place of primacy in her equation. Cultural knowledge is also an important characteristic, but, according to LF, knowledge itself does not make someone competent unless that person also possesses sensitivity. In fact, if you only hold one of these characteristics, it would be more important for you to be sensitive and aware than to just be knowledgeable.

> *If you're sensitive without the knowledge, I think that is more important than having the knowledge, 'cause you can obtain the knowledge if you have to.*

Sensitivity includes both self-awareness, and an empathetic awareness of others and what they have experienced, according to LF. She believes that self awareness includes recognizing that you don't know something, that you need to do something about it, and having a sense of why you should do something. Awareness of and sensitivity to others includes knowing that differences occur and are important, and having the ability to see the world through another's eyes. It makes you realize the need to learn more in order to be more skilled in cross-cultural interactions. LF believes that this sensitivity will actually push people to seek out and gain more knowledge.

The kind of knowledge one must seek to be culturally competent ranges from knowing (at least a little) the language of another person, understanding the meaning of family and their culture as they describe it, and what is important to another person. Knowing about differences is important. One way to gain this knowledge is by personal interactions with people who differ from yourself and asking genuine

questions. Another method is to educate yourself by reading or studying about others. Gaining knowledge is an active process for LF, but knowing doesn't necessarily lead to effective behaviors.

[It's] hard to know what to do. . . I mean if you have an idea it's hard to orchestrate it.

LF identified several behavioral strategies that support cultural competence, most of which relate to communication skills. Trying to speak the language of someone who is different, talking together to confront differences and getting to know people as individuals are high on LF's list of communication skills. Her main emphasis was just to *try*. She stated that being open-minded and just trying to communicate was being culturally competent. LF believes that doing something is more culturally competent than doing nothing or ignoring differences. She believes that *taking responsibility* to do something is an important trait.

There are also important behaviors that one must *not* engage in if attempting to be culturally competent. This includes judging people, avoiding or ignoring people who are different, refusing to engage with others, or not making the effort. This list emphasizes LF's belief that *taking action* is a vital aspect of acting culturally competent.

Finally, as we move towards cultural competence by possessing all the above characteristics and actively engaging with people who differ from ourselves, LF believes that true understanding will occur. She defines this as a depth of awareness that moves toward empathy. In her words, it is *really understanding*, not just a superficial recognition of one another. She also believes that a feeling of happiness, and a sense of closeness and appreciation will also accompany true understanding and be part of the outcome of effective culturally competent interactions.

In the next example of an Individual Textural Description, J.M. describes the meaning of cultural competence in a somewhat different way than did L.F.

JM: Participant #3
Individual Textural Description

JMs experience in cross-cultural situations have ranged from those she describes as *culturally incompetent* to *culturally fluent.* She identified a developmental process that occurs as people learn to interact with one another that incorporates incremental skills and behaviors. The levels begin with *cultural sensitivity* and then move to *cultural competency* and then, for some, to *cultural fluency.*

A person who is **culturally sensitive** has an awareness of self and others, and recognizes and challenges her own assumptions. For JM, a person at this level is still pretty ignorant about cultural differences and carries many assumptions or stereotypes about people who are different. Cultural sensitivity is the beginning of the process.

> *. . . Cultural sensitivity, I think, is just an awareness that there are other cultures around. There are differences. And awareness of one's ignorance of them and the willingness to seek out what the differences are.*

JM emphasized how ignorant people are initially, and the primacy of recognizing this. She described her own process regarding her interaction with an African American man who gently confronted her.

> *Well, I think first of all, we have to admit that we're ignorant (about people who are different from us and how to interact with them). I think that's the first problem. I admit to it freely. I am totally ignorant. . . But in a small way he had educated me, at least enlightened me on my ignorance. And that is always the first step.*

For JM, self-awareness increases in a manner similar to consciousness raising. You realize that you are ignorant, and as a result, you become more aware of the differences in people in a way that was not available to you prior to that time. Part of that awareness is a recognition of the assumptions that you hold about people who are different, and a *willingness to let go of those assumptions.* JM recognizes

that this increasing awareness of self and others gives a person more choices about how to interact with others. She asserts that *we must know more about ourselves before we go out to know others*. JM also believes that this self-knowledge will cause one to seek out more information about other cultures in an effort to try to understand them better. This process moves someone into the level of **cultural competence**, according to JM.

Cultural competence incorporates knowing and understanding about others, as well as demonstrating effective skills or behaviors. At this level, people understand and can speak one another' s language, and they have a willingness to understand others at a basic level. JM refers to this as almost like *having a rule book.* Within that rule book would be information about that person's beliefs and value systems, the habits of the people, the norms of the culture, and a knowledge of what is accepted and what isn't. It's knowing what people do as part of their daily lives, as well as understanding their spiritual and social life. Having this knowledge allows people to interact in a competent manner with one another.

JM emphasizes that interacting is an active process of ongoing exposure. She describes it as *thrusting* yourself out there, and continuing to do so.

> *You have to be face to face with the person, and you have to be on a daily basis. That's what I mean by exposure. You have to thrust yourself in there.*

And if you get rejected

> *You try again. You keep going and going because the person who is unwilling to learn will not come back. But if you are willing, if you really are committed to understanding their culture, you will come back.*

So, for JM, the experience of cultural competence is not for the faint hearted. It takes commitment to the process and a willingness to put yourself out there, if necessary, over and over again. As JM states, it takes *time* and *work.* But the results are worth it. JM described several culturally competent interactions where people worked collaboratively, learned to trust one another, and were welcomed in each other's company. There is a feeling of acceptance and equality as a result of

theseinteractions.

During one experience, JM was observing at a shelter for homeless women in the Boston area, and noticed the way a staff member interacted with a small group of Haitian women by speaking French Creole to them. The staff member

> *encouraged them to talk as much as they were willing to. . .and was really willing to listen (to them). She was welcomed. It seemed like she was a trusted person. . . This staff woman went over and sat with them as an equal, and they let her join them at the table. I think they were maintaining the equality, the feeling of equality, and she was accepted as such.*

For JM, being able to work together in a collaborative manner is a major reason for becoming culturally competent. In a health care setting this translates into timely and effective treatment, and the development of trust between the client and the health provider.

JM identifies another level beyond cultural competence, however, that she calls **cultural fluency.** Not everyone reaches this level of expertise. She sees *a lot of work between cultural competency and cultural fluency.* She bases this on her premise that one must have considerable experience in cross-cultural situations in order to reach fluency.

> *I think cultural fluency is very much based on experience. I think it [helps] to understand the innuendoes, to understand the subtleties, and not only that, but I think the mark of being culturally fluent is to. . . when faced with an unexpected situation that crosses cultures, you're able to handle it.*

JM's examples of "unexpected situations" include the arrival of a family from an unfamiliar culture who seeks health services, or when an Hispanic family, who traditionally takes care of their elderly, chooses not to. Someone who is culturally fluent would relate effectively in these situations because she would know *how to go outside the rule book.* She would have an awareness of how to interact with this family to gain the needed information for effective communication.

JM compares this concept to the notion of being fluent in a language. Someone can learn a language, but rarely speaks fluently unless spending time with a culture that speaks the language. JMs theory of cultural fluency is very similar. Someone can understand another culture and interact in a culturally competent manner, but if that person has had a lot of experience within that culture, she could become culturally fluent. Some of the characteristics of cultural fluency, according to JM are being *very comfortable [with] back and forth [interactions], [having] good confidence,* and the *abil[ity] to get through* to others. It's knowing how to deal with the unexpected in an effective manner because of having a deeper understanding of the subtleties of a culture. In some ways, the culturally fluent person as described by JM would be almost acculturated into the other culture, having knowledge and skills far beyond those found in people who are culturally sensitive, or even culturally

JM does not see herself at this level yet, nor am I sure that she even perceives of herself as culturally competent, but she recognizes people who exhibit these characteristics, and aims for that goal for herself. She values the goal of cultural competence in health care and believes in its importance for effective treatment.

Individual Structural Descriptions

Structural descriptions provide "a vivid account of the underlying dynamics of the experience" (Moustakas, 1994, p. 135). This part of the analysis describes the "how" of the experience, attempting to understand in more depth how the participants experience the phenomena the way they do. The following are the individual structural descriptions of the experience of cultural competence and culturally competent care by L.F. and E.B.

LF: Participant #1
Individual Structural Description

LFs experience with and perception of the phenomenon of cultural

competence is certainly influenced by the fact that she is Jewish. Although she states *I think I align myself a little more with the majority that I was talking about earlier* (whom she had described were Caucasians, wealthy males, holding power positions), she also recognizes that her cultural and religious differences set her apart from that same majority. What makes her part of the majority is her skin color which is white. LF recognizes that this characteristic gives her cultural power in this society, and she is sensitive to the meaning of that.

> *I want to be aware of when I am . . .in a power situation and I'm the one with the power. I don't want that ever. I want to make sure that I can make my interactions so that I am on equal footing with the other person.*

She also recognizes that she will carry the power of authority as an occupational therapist.

> *I think that a lot of people (when I am gonna be in OT) will view me as a professional and see me, you know, in a place of power, and I don't want that.*

Although LF may be unable to prevent the way others will view her as a professional, it is important that she be aware of and sensitive to these issues of power and authority. LF is also aware that her difference, her Jewish identity, is not visible at first glance, so it is easier for her to "pass" in this society.

> *I do [feel like a part of the majority culture], but I also am Jewish, so I can relate a little bit. I am white, which you can't see the difference in me, but I feel it. I feel a little different, a little unique from the majority culture sometimes.*

When comparing her experience to that of a Black man she had met, she states,

> *But it's just much more visible for him. I mean, people can look around and say that is the only black man. No one can do that for me.*

Yet it is her "invisible" difference that increases her awareness of others who are different. When talking about her sensitivity to and awareness of a lone Black man she met in a public place, she related it to her awareness of herself in a minority status.

I think being Jewish had something to do with that. Because I was probably the only Jewish person in that bar too.

LF recognizes her dual status in US society. She is White, and therefore holds cultural power simply by the color of her skin. Yet, she is also Jewish, which places her outside the Christian majority status as well. Because of her cultural self-awareness, and her own personal sensitivity around the issues of people treating her well, despite her differences, LF has developed an acute sensitivity to other people who are different. This may be why she believes in the primacy of the characteristics of sensitivity and awareness.

Because she has been hurt by an insensitive comment from a teacher whom she thought was knowledgeable about cultural difference and whom she trusted, LF stresses that sensitivity is more important than knowledge in cross-cultural interactions.

If you're sensitive without the knowledge, I think that is more important than having the knowledge, 'cause you can obtain the knowledge if you want to.

Yet, knowledge is important to LF. When someone *take[s] the time to learn more about [her]* in an effort to understand her and her culture, she believes that is a move towards cultural competence. She doesn't mind being asked questions - even ridiculous questions - if the person who is asking is genuinely attempting to learn more about her. On the other hand, LF believes that cultural incompetence is the lack of knowledge and the lack of effort to learn more about someone else and their culture. It is ignorance.

LF believes that seeking and giving knowledge is a dynamic that should occur in cross-cultural interactions. As a person who is Jewish, she believes that it is her *responsibility* to educate others about her culture/religion. In an effort to be more accurate about the information she gives others, LF bought a book about about the Jewish culture and shares some of that information with others when they ask. She also believes that spending time with people who are different from yourself, and asking questions about their culture, is an important method of gaining knowledge.

Sensitivity and knowledge do not necessarily lead to cross-cultural skills, however. LF laments the instances when she doesn't know what to do, and it leaves her feeling incompetent. Doing something is important to LF. If people at least make an effort, if they try to engage with others, then they are moving towards cultural competence. She related the story of a young man who was asking her a lot of *ridiculous* questions about being Jewish. His ignorance made him culturally incompetent in LF's eyes, but she stated,

but his asking me was culturally competent.

The fact that he was trying to learn about her, and was courageous enough to ask questions, no matter how ridiculous they might have been, made her perceive the interaction in a positive light.

LF can identify several behaviors demonstrated by culturally competent people when interacting with others. Many of these reflect the way she would like to be treated as a Jewish woman. She was very specific in her listing of these strategies, and I wonder if her own experiences aided in the development of that list. For LF, the outcome of cultural competence is *true understanding* which is coupled with *happiness* and a sense of *appreciation* for one another. I believe that this is what LF seeks for herself.

JM: Participant #3
Individual Structural Description

JM was raised in a town that included very few ethnic people (*one black family and two or three Jewish families*), and she believes that because of this she was "ignorant" when it came to interacting with people who were different from herself. Not only was she unknowledgeable, she was also fearful.

Yeah, I just simply know nothing. As a matter of fact, when I . . . moved to Boston, I was terrified of black people. I just assumed they were going to mug me. . .

She attributes that fear to her lack of face-to-face exposure, coupled with the images

and stereotypes she learned from the media. It wasn't until she experienced a gentle confrontation with a courageous young Black man that she began to evaluate her assumptions and become aware of her ignorance.

JM's resultant concern with racism and the separateness caused by and contributing to racism, influences her perception of culturally competence and cross-cultural interactions. For JM, one of the major reasons for interacting in a culturally competent manner is the importance of collaboration, of working together to solve problems, which is the opposite stance from the separateness that is so apparent to her with racism. Developing trust between people, welcoming one another, and treating one another as equals are also important results of cultural competent interactions from JMs perspective.

JM is quite emphatic about the way someone goes about developing culturally competent or culturally fluent skills. She firmly states that you have to put yourself out there, that you have to even thrust yourself into cross-cultural situations. This is not a passive process. If a person is committed to cultural competence, then she must expose herself to others who are different from herself over and over again. It is quite clear that this notion of exposure arises from JMs concern that she had little exposure to people of different ethnicities during her developmental years. Perhaps this idea also results from the African American man who was courageous enough to confront JMs fear. She was quite awed by his courage during that interaction, and may have used him as a model for effective interactions.

> *It was very brave of him too, 'cause he didn't have to do that. But in a small way he had educated me. At least enlightened me on my ignorance.*

JM's emphasis on exposure to others who are culturally different also influences her concept of cultural fluency. She sees this level of interaction as a step above cultural competency, and likens it to language fluency. Someone can learn the rudiments of a language, but rarely speaks fluently unless spending time with a culture that speaks the language. Similarly, a culturally competent person can know about and understand another culture, and may have developed skills to effectively

interact in usual circumstances. However, only someone with significant experience within the culture can rise to the level of cultural fluency as defined by JM. That person can then *understand the innuendoes, understand the subtleties,* and *when faced with an unexpected situation that crosses cultures, [be] able to handle it.* The culturally fluent person can respond beyond the expected; they know *how to go outside the rule book.* JM admits that not everyone reaches this level, but I sensed an underlying yearning that she hoped she would one day achieve it.

Moving from ignorance to cultural fluency takes time and hard work, admits JM. In fact, at this point in her own development, this process still feels like work to her. She has not yet moved to the place of excitement, joy, or wonder that others have identified. JM often spoke of herself as still being quite ignorant, but willing to make the effort. She does believe, however, that moving to cultural competence is extremely important for health professionals. She stated that it was vital for effective and timely treatment of clients.

It was interesting to me, that even though she didn't see herself as much beyond the level of cultural sensitivity, JM was able to clearly articulate a cohesive developmental progression of skill and knowledge related to cultural competence. This suggests that one may know what to do, and how to achieve it, without actually yet developing the skills and necessary behaviors.

Thematic Analysis

In order to construct the Composite Textural Description of the phenomena of cultural competence, I examined the themes of every participant to depict the experience of the group as a whole. The following account describes that analysis.

The study participants were all quite forthcoming in discussing their experiences and ideas of cultural competence and culturally competent care during the interviews. Although they each approached the issue differently, all of them identified what a culturally competent interaction should and should not look like, and

more clearly, what a culturally competent person is like, whether the experience is in a clinical setting or not. From the examination of the data three themes emerged. Theme one identifies the attitudinal levels that lead to cultural competence. The second theme, characteristics of a culturally competent person encompassed three categories, or sub-themes, while theme three identified the outcomes of a culturally competent interaction.

Theme One: Attitudinal Levels that Lead to Cultural Competence

Theme Two: Characteristics of a Culturally Competent Person

1. maintains an attitude of willingness,
2. is knowledgeable, and
3. demonstrates particular behaviors.

Theme Three: Outcomes of a Culturally Competent Interaction

Theme One: Attitudinal Levels that Lead to Cultural Competence

Theme one was discovered only after a thorough reexamination of the data. I decided to identify it as the first theme because I believe it frames what follows. Some researchers believe that cultural competency occurs as a developmental process. Cross et al. (1989) designed a cultural competence continuum that ranges from Cultural Destructiveness to Cultural Proficiency and which was described in detail in an earlier chapter. Although the data from these study participants cannot be organized into a true developmental sequence, the attitudes they describe are suggestive of some of the levels identified by Cross et al., and can be placed in the following hierarchy.

Attitude	Level of Competence
Ignorance	Cultural Incompetence
Tolerance	
Openness to Difference	Cultural Sensitivity
Acceptance	Cultural Competence
Appreciation	Cultural Proficiency (Fluency)

Ignorance

An attitude of *ignorance* is a state of being unaware or uninformed (Merriam - Webster, 1995). One participant described herself this way and the resultant fear she felt of African Americans because she knew so little about them.

> *I admit it freely. I am totally ignorant. Yeah, I just simply know nothing. As a matter of fact, when I moved to Boston, I was terrified of black people. I just assumed they were going to mug me. (#3)*

This student spoke about her lack of experience with people who were culturally different from herself, and the stereotypical knowledge she had gained from the media. This resulted in her erroneous assumptions about an entire group of people and her sense of fright when she interacted with Blacks.

Another student spoke of ignorance and stereotyping as cultural incompetence which results in cultural mistakes. To her, ignorance is not just "a state of being unaware or uninformed" (Merriam-Webster, 1995), but is also an attitude which disallows a person to learn.

> *Ignorance is where a lot of things go wrong. . . and ignorant people tend to be culturally incompetent because they lack that openness to learning. (#12).*

Therefore, an attitude of ignorance can result in stereotyping, making false assumptions, fear, and making cultural mistakes which can be hurtful. This description reflects Cross et al.'s (1989) developmental level of Cultural Incapacity. Cultural incapacity occurs when people and agencies "do not intentionally seek to be culturally destructive, but rather, lack the capacity to help. . . [They] remain extremely biased. . . discriminate against people of color. . . may act as agents of oppression by enforcing racist policies and maintaining stereotypes. [They] are often characterized by ignorance and an unrealistic fear of people of color (p. 15).

Tolerance

The next attitude identified by the study participants was that of *tolerance*. One student defined it this way:

> *I guess tolerance would be not being disrespectful. I think you can be tolerant without being accepting. Tolerance is a surface [attitude]. (#8)*

This student experienced tolerance from her boyfriend's parents and her own grandmother. She is Jewish and her former boyfriend is East Indian. His parents treated her with *respect in [her] face - to - face reactions with them,* but then her boyfriend's father had *a screaming fit at him for dating outside his race.* His parents tolerated them dating, but she never felt accepted by them. This student also told the story of her grandparents volunteering in the V.A. Hospital in the Bronx, working with people who were Hispanic and African American, and apparently enjoying it. But when Hispanics and Blacks began to move into their neighborhood, they moved. Although her grandparents talked about the respect they held for people different from themselves, their actions (moving out of their neighborhood when culturally diverse people began to move in) indicated something different. It's something like, people who are different are okay in their place, but their 'place' cannot be my neighborhood! This participant (#8) recognized this behavior as another example of verbal tolerance rather than of acceptance.

Another study participant described intolerance as

> *. . . [not trying] to understand where [people] are coming from, what their backgrounds are. [Lacking] a mind set of what people are willing to accept and willing to experience and whether or not they want to learn about other people. (#4)*

Although this sounds a little like ignorance, the difference is that there seems to be more of a choice in tolerance the way it is described by this participant. This seems to indicate, then, that tolerance is also a choice. People decide that they are going to be respectful of, and try to interact with people who are different. However,

there is not true acceptance of these people. An attitude of tolerance falls somewhere between Cultural Incompetence and Cultural Sensitivity as identified by the study participants, and does not reflect any stage described by Cross et al. (1989).

Openness to Difference

As might be inferred by some of the statements above, the next attitudinal stage in this hierarchy is *openness to difference* which correlates with Cross et al.'s level of Cultural Sensitivity. One student described cultural sensitivity as

> *. . . knowing that you need to put out effort. Knowing that you need to recognize things, knowing that there are differences, and [that] they are important, but not necessarily knowing what to do about that. (#1).*

This student related the story of a faculty member of hers who valued cultural sensitivity, often talking about its importance in class, and recognizing the difference in this participant's Jewish Identity. However, the teacher made the hurtful mistake of wishing participant #1 "Merry Christmas" during the holiday season. She knew about difference, recognized the student's unique culture, but then did not act appropriately given that information. This participant distinctly separated cultural sensitivity from cultural competence, and actually identified sensitivity as a precursor to competence.

> *I think cultural sensitivity leads to more knowledge and then leads to cultural competence. (#1).*

Another study participant agrees with this. She describes a hierarchy in which cultural sensitivity is the first step towards cultural competence.

> *Cultural sensitivity is an awareness that there are other cultures around [and] there are differences, an awareness of one's ignorance of them and the willingness to seek out what the differences are. (#3)*

Openness to difference encompasses not only an awareness of difference,

according to these study participants, but also the recognition that difference is important, especially to non-majority people, and that culturally sensitive people are willing to seek out and learn more about those differences. Some people erroneously believe that the correct approach in cross-cultural interactions is to ignore difference, to treat everyone the same in an effort to appear unbiased. This is often referred to as "color blindness", defined as "the state of not being subject to, or cognizant of racial differences" (Herbst, 1997). Cross et al. (1989) identify this as Cultural Blindness, and state that if you ignore cultural differences, you are also ignoring cultural strengths. This then leads to a lack of recognition and value of the individuality of each person. In contrast to that notion, the study participants recognize that it is important to recognize and honor difference.

Cultural sensitivity, as identified by the study participants, and the attitude of being open to difference, reflects some of the aspects of Cross et al.'s (1989) Cultural Pre-Competence. The authors state, "This term was chosen because it implies movement. . .an agency realizes its weaknesses. . . and attempts to improve. . . [including] initiating training on cultural sensitivity. The pre-competent agency, however, has begun the process of becoming culturally competent and often only lacks information on what is possible and how to proceed" (p. 17).

Acceptance

The next step in this process is Cultural Competence which is characterized by the attitude of *acceptance.* One student defined an accepting attitude as

> *It's just being open, not making judgments, taking things for what they are, and try[ing] to shelve your own judgments and going with the flow. People who are culturally competent tend to be more open-minded about things. Everybody's perspective is heard. (#12)*

To another student, being accepting meant

> *. . . being respectful of people's differences and their own values. It doesn't necessarily have to interfere with yours. They can have*

their opinions and cultural practices and you can have yours. . . . you go beyond tolerance to bridge that gap and make sure that there is communication and understanding. Acceptance goes deeper than tolerance.(#8)

This attitude of acceptance as part of cultural competence moves beyond merely having a particular attitude. As the above student stated, It is also demonstrated by the way we communicate and other skills. This will be explained further as part of the analysis in theme two. Another student talked about acceptance with the following example.

The differences would be there, but respected and not expected to change. If I was in their country (Arab), I would do what they do. I would try to get to know them and the differences so I'm not too pushy and more understanding. I don't pretend to know more about the Arab country, but I know women aren't treated as well as men. So I accept that. (#5)

This participant's response, as does those above, raises the question of blind acceptance as an aspect of cultural relativism. This notion will be discussed in chapter five.

Cross et al. (1989) states that "Culturally competent agencies are characterized by acceptance and respect for difference, continuing self-assessment regarding culture, careful attention to the dynamics of difference, continuous expansion of cultural knowledge and resources, and a variety of adaptations (p. 17). This description closely aligns with the descriptions offered by the students above. Interestingly, however, cultural competency is not the ultimate goal for either Cross et al. or for at least one of the study participants.

Appreciation

The highest level on the continuum of cultural competence is called cultural fluency by participant #3, and Cultural Proficiency by Cross et al. (1989) and is

identified by an attitude of *appreciation*. Cultural fluency only happens with people who have had extensive experience with a cultural group. You not only have knowledge about a culture, but also can recognize and respond to the subtle meanings within a group.

> *I think cultural fluency is very much based on experience. [You] understand the innuendoes, understand the subtleties. I think the mark of being culturally fluent is when faced with an unexpected situation that crosses cultures, you're able to handle it. (#3)*

This student went on to say that cultural competency is *almost like you have a rule book*. And with cultural fluency you *go outside the rule book*. It is a level of interaction that comes from a deep appreciation of the culture. Cross et al. (1989) describe it as an advanced level of competence "characterized by holding culture in high esteem" (p. 17). Not everyone achieves this level of competence in cross-cultural interactions, but it may be something to strive for.

In summary, the study participants as a group identified several attitudes held by people at various stages of cultural competence. These findings correlate with the Cultural Competence Continuum identified by Cross et al. (1989) and lead us into a closer look of the attributes of cultural competency identified by the participants.

Theme Two: Characteristics of a Culturally Competent Person

Although the three areas subsumed under attributes were similar to those found in the literature, the study participants emphasized some unique perspectives.

Attitude of Willingness

One of the most important attributes of a culturally competent person expressed by the study participants is an attitude of willingness. Throughout the transcripts of the interviews, the word *willing (ness)* kept popping up. I saw it so

often and through so many voices that it couldn't be ignored. I was struck by this notion as I began my analysis.

A few of the ways the study participants talked about willingness were

willingness to seek out what the differences are (#3)

willingness to find out what's really going on (#3)

willing(ness) to accept and experience (#4)

willing(ness) to listen (#2) (#6)

willing(ness) to understand their situation (#2)

willingness to let go of our assumptions (#3)

willingness to learn (#4) (#6)

willingness to be open, and listen, and understand (#6)

willing(ness) to admit you don't know anything (#6)

As I thought about this concept of *being willing to do* something, I recognized that the students were talking about making a conscious choice. They were talking about a volitional act. Occupational therapists understand the importance of volition as part of the theoretical construct surrounding occupational performance. Kielhofner (1997), when discussing the Model of Human Occupation, defines volition as "a system of dispositions and self-knowledge that predisposes and enables a person to anticipate, choose, experience, and interpret occupational behavior" (p. 190). We might infer from this definition that a culturally competent person maintains an attitude or disposition that allows her to not only be open to certain experiences, but also to choose them. The participants stated that a person who is culturally competent chooses to have an open mind, chooses to be self-reflective, and chooses to attempt things beyond her comfort zone.

A willingness to look at the world with an **open mind** was a consistent theme of most of the participants. However, they each identified this concept in unique ways. One student spoke of it this way:

Being open means being observant and being willing to if you see something that's different, accept that or take that in, incorporate it into your session. So open means absorbing what's around the

culture, aspects of the culture, and using that then to change your own behavior. (#7)

She gave the example of a Russian man who spoke little English but his adult daughter would translate for him. The daughter worked odd hours and could not always be with her father. The therapist rearranged her schedule so that she could work with the man when his daughter was available so that he would receive the treatment that matched his cultural beliefs and needs.

Another participant said:

To me it means never making a judgment without having the information to back it up. Even being open minded to the fact that down the road if I have an opinion or something formulated and something very valid presents itself to change my mind, that I'm open to changing my opinion. (#10).

A third articulated it this way:

It's being open to hearing what they're saying and maybe where they're coming from, and trying to get a real understanding of what's making them feel the way they do or see things the way they do.(#4)

Another participant summarized it this way:

People who are culturally competent tend to be more open-minded about things whereas people who aren't are more one-track mind[ed]. . . . [Being open] is not making judgments, [but] taking things for what they are, try[ing] to shelve your own judgments and going with the flow. I don't think you'll get very far unless you are open minded. (#12).

Summing these ideas up, being willing to be open minded means being accepting of others and not judging them. It means recognizing difference and being willing to learn about and from it and incorporating that knowledge into a treatment session. It means being aware of and being willing to listen to another's point of view. It may also mean choosing to set aside your own beliefs and values for a time as you learn about and 'try on' the beliefs and values of others. In an occupational therapy setting, it may mean setting goals with the client that are culturally important

to him, rather than choosing treatment activities that are therapeutic, but may have little or no meaning for the client. For example, helping a client with a stroke to make simple meals for himself before returning home is a typical treatment activity. However, if an Arab man has female family members who will do this task for him, it does not make sense to encourage him to do this. Instead, the occupational therapy practitioner should talk with the client and his family about the daily activities that are meaningful for him to accomplish on his own, and together, work on helping him achieve that goal.

With open-mindedness comes **awareness of self and others.** Although over half of the participants spoke of the importance of being aware (particularly of others), I was surprised to hear only a few specifically talk about self-awareness. This greatly contrasts with the literature that states that self-awareness may be the most important of the characteristics of a culturally competent person (Chan, 1990; Harry, 1992; Weaver, 1999). The students who did speak about self-awareness, however, were quite articulate. One student believes that part of knowing yourself is not only being able to identify your strengths and weaknesses, something we often talk about as occupational therapists, but being able to recognize what we don't yet know (in a cross-cultural situation) and being willing to admit it. She stated,

> *They would be aware that they didn't know much about the person [and they would have] the awareness of their lack of knowledge. And I think it's important for them to not know. . . They don't know, but they do know themselves. . . They know who they are, but they also know that they're not the same person and hold the same beliefs and values that everybody else does. (#6)*

This student believes that self-awareness is very important. Not only should we recognize our own lack of knowledge about others, but we should be aware of

> *what our first choice would be, what our initial instinct would be to do. . . and then realizing that your initial instinct isn't everybody else's.*

According to this participant, we must be aware of our initial thoughts and ideas, our "instincts" when we first meet and begin to interact with someone who is

culturally different, and immediately evaluate those ideas to determine how they will fit in this particular situation. By being aware, we can then make choices about our behavior. She believes that

> *you need to be comfortable with yourself before you can be comfortable in a situation, and you know you can't really be comfortable with yourself if you don't know yourself. (#6)*

The ability to assess your own strengths and weaknesses, to recognize your lack of knowledge, puts you in a ready state for learning; a place of openness. Self-awareness allows you to *anticipate where the problem areas might be* during cross-cultural interactions. As this student so articulately states,

> . . . *you come from a clearer place. You know what you're dealing with if you're aware. . . and if you find yourself in a situation and something comes up,* (such as inadvertently saying something that offends the person you're interacting with), *you know that's one of those learning moments when you realize, wow, I never realized this about myself. This is something to keep in mind in case it comes up again. (#6)*

This kind of "reflection in action" as described by Schon (1995) can only happen in this way if you are truly self-aware. Another student emphasized the importance of being aware of your own opinions or values, warning that being unaware of these things might cause you to make unintentional cultural mistakes. For example, using the term "sexual preference" is sometimes offensive to people who are homosexual, yet many heterosexuals do believe that homosexuality is a choice. Using the term above may indicate your own values and beliefs, or it may be a cultural blunder - a lack of recognition of the terminology that people prefer. *[S]ometimes it comes out and you just realize that you had no idea.* (#4) Knowing yourself, and being aware of your own beliefs about homosexuality might prevent this from happening.

Self-awareness is a knowledge of one's internal world. Although, as I stated earlier, only a few students mentioned this, the majority of the study participants

spoke about being aware of factors in one's external world. This will be discussed further under the section on having knowledge. Awareness of self and others, tied with open mindedness, closely aligns with respect, another concept and attitude identified by the majority of the participants. One student stated *You're supposed to respect other people . . . and their differences. (#6)*. She talked about the importance of showing respect by listening to people and trying to learn about and from them. It's not pushing your own ideas on others, but rather, recognizing each person's uniqueness and valuing him/her as a person. You have to be willing to see the other person as an individual, and to do that you must be willing to accept that person. Openness to, awareness of, respect for, and acceptance of someone who is different from yourself is seen by one of the participants as *cultural sensitivity*. The students who spoke of this felt that it was a vital aspect of cultural competence. When comparing awareness or sensitivity to the cultural characteristic of knowledge, one student said,

> *I think it's better. If you're sensitive without the knowledge, I think that is more important than having the knowledge, 'cause you can obtain the knowledge if you have to. (#1)*

Another stated that what makes the difference between a culturally competent interaction and one that is not, is the awareness. According to these students, you can have knowledge about another group of people, but without awareness (of self and others) you will not be culturally competent. On the other hand, someone who has cultural awareness but does not' t yet have much knowledge about the culture might be considered culturally competent. This is because awareness seems to correlate with a willingness to learn. It appears then, that this attitude of willingness is a vital attribute that a culturally competent person must possess.

The term awareness was also used in a unique way by one student who spoke of the *heightened awareness* that she experiences during cross-cultural interactions. She was entering the home of a Japanese co-worker and wondered whether she should remove her shoes.

> *Right at first when I was coming in, and when I was in that awareness,*

and I just wanted to check out how we should be acting. . . it's a heightened awareness that you don't normally have when you're acting in your own culture. (#7).

This sounds like alertness, or the increased arousal that often occurs with people during new situations. But this student went on to talk about how it causes her to be more observant, and to listen more rather than talk. Actually, this is a positive adaptive response to a new situation, and it seems to be especially appropriate during cross-cultural situations.

The final attitude of willingness that was integrated throughout most of the transcripts was a **willingness to try.** One student talked about her attempt to speak Spanish to some Hispanic co-workers, even though she doesn't know the language well.

They really, really liked it and it helped to get us a little closer (#1).

She feels that being willing to try new things, new behaviors, new modes of communication, is an important aspect of cultural competence.

Try to get on the other person's wavelength a little bit and show that you're interested. Try to understand the differences. (#1).

Being willing to put yourself in this position during a cross-cultural interaction is being willing to make yourself vulnerable. It's *putting yourself out there* where the chance of failure is much greater than when you are with groups of people with whom you are familiar and comfortable. Being culturally competent is not for the faint hearted. It takes courage and confidence to willingly put yourself in a position of vulnerability, but the study participants spoke clearly about the importance of doing just that.

You have to thrust yourself in there. You have to make the effort. Really get your foot in the door. You can choose to actively expose yourself to varying degrees. (#3)

When asked what happens if you are rejected when trying out new skills, one student responded:

You try again. You keep going and going because the person

who was unwilling to learn will not come back. But if you are willing, if you really are committed to understanding their culture, you will come back. (#3).

According to this student, having a willingness to try means being committed to the process of reaching out to others who are different. It means not only allowing but also actively choosing (volition) to be vulnerable, and maybe even being rejected, but having the courage and commitment to try again. Although the participants were referring here to personal situations, the concept of willingness also holds true for clinical situations where practitioners must be willing to put the extra effort into getting to know and understand the culturally different client in order to provide the best possible care.

To summarize this attribute of **maintaining an attitude of willingness**, as voiced by the study participants, you make a conscious choice to maintain an open mind about others, which involves respecting and accepting them. You also willingly increase your self awareness and your awareness of difference and similarities regarding others. And lastly, you take the opportunity to *thrust yourself* into cross cultural situations, in order to try to improve your interactions with someone who is different from yourself.

Being Knowledgeable

The second attribute of a culturally competent person that every one of the study participants identified was being knowledgeable. During their interviews, the students talked about why it is important to be knowledgeable, what you should know, a variety of ways to learn, and the dynamics between knowledge/learning and the first characteristic, having a willing attitude.

One of the most identified reasons for learning about other cultures is to help you **be prepared** to interact more effectively. The following participant spoke about the preparation that is needed in a clinical situation.

In the ideal situation you have some nice amount of time beforehand

and have an idea of. . . perhaps what the person's background is or a little bit about them. . . . you can look it up, educate yourself a little bit about it. But in the situation where you have five minutes and you've looked at the (medical) chart,. . . then I think it can also just be a mind set as to preparedness. Realizing that you're going into a situation where you're going to need to probably ask more questions and need to elicit more information. (#4).

It's interesting that this participant identifies being prepared also as a mind set, an awareness that you may have to change your behavior in a particular way. But again, she states that ideally, you would learn about the culture of another person before interacting with him/her. Other students concurred. One stated,

I read a lot and have people tell me about things, and so, I learn to face them as heads first. (#6).

This same student went on to talk about how that kind of preparation allows her to anticipate what to expect in a cross-cultural interaction. Another spoke of the importance of having knowledge when you're in another person's home. She said that you fit in by

. . . learning and having knowledge before you go into a situation so that you're prepared for, know what to expect or what to look out for. (#7)

This student also talked about the ideal situation as being one of being prepared through knowledge.

I think ideally . . . they knew ahead of time that they would try to find out about cultures, about the customs. . . . The therapist would prepare herself beforehand to know the sort of dress and the customs about what you do when you're inside the house. (#7).

In a somewhat different situation, where a student was involved in an international experience where she and her team would be providing services to children but would be in a minority status herself, preparation was still very important. She related how a faculty member prepared them for an academic trip to Rumania

by teaching her and others about the culture. The participant reported that the faculty member told them

> *. . . it was going to be a difficult experience and you kind of have to start with an open mind. There are going to be things that you see that you're not going to like. You're just have to understand where everybody's coming from. I think she did a good job preparing us. (#9)*

So with that additional knowledge given to her before her trip to Rumania, this student felt quite prepared to embark on the experience.

What kind of knowledge is important to help someone feel more prepared in a cross-cultural interaction? Generally, the study participants talked about knowing the cultural differences and similarities, but they also clearly identified many specific areas of knowledge. These included learning about :

their dress and customs (#7)

their interaction patterns and level of formality (#7) (#1)

their foods and their eating patterns(#7) (#12)

non-verbal communication patterns such as eye contact and gestures (#7) (#8) (#10)

what they value; what is important to them (#6) (#10) (#5)

what you may have in common (#6) (#12) (#4)

their day-to-day experiences, their routines (#9) (#3) (#5)

their language (#9) (#1) (#3)

what is culturally relevant to them (#11)

what is going on in their homeland (#12)

their religion, spiritual life (#12) (#3)

their perceptions of wellness, illness, death (#12)

what their family life is like (#1)

what their culture means to them (#1)

what our culture means to them (#1)

what it means to them to be part of a minority culture (#1)

the subtleties of the culture; those things that are not necessarily expressed openly (#3)

their social life (#3)

This is a significant and extensive list, and to me indicates that learning about another culture or cultures involves a time commitment that might be lifelong in practice. It is interesting, however, that this list identifies information that needs to be learned about the other person or group, but does not discuss what the participants need to know about themselves and their cultural identities, or about the societal role each person is given.

How do you begin to learn about others? The study participants identified numerous learning strategies. You can learn through formal education, and many stated that they had learned this way. You can also learn by individual reading and research, which, along with continuing education offerings, is probably the most likely learning strategies for practitioners. Another student suggested reading pertinent non-fiction books about other cultures as a way to learn. A good example of this is Fadima's (1997) *The Spirit Catches You and You Fall Down* which is a compelling story of the experiences of a Hmong family with the American medical system.

Maybe someone could become more culturally competent if they read books that . . . showed a different perspective in another culture. I would say that they should try to find inspiring novels. (#11)

Although all of the above learning strategies are effective, the method that seemed to have the most impact on the majority of the study participants was **personal experience with cross-cultural interactions.** Many of them spoke about experiential learning that was transformational to them. One student stated,

. . . things change me when it directly happens to me. I mean, I can read about things and know more, but I think [the experience] really impacted me. (#1).

Another added:

Traveling and meeting other people and having those experiences are . . . the best thing. That's how I grow and have become who

I am is by knowing people with different experiences, and trying to experience some of these new things also. Because a lot of this stuff I've done in my life, I never would have done if I hadn't met people who were different from me. (#4)

Another student talked about her trip to Rumania, and how it impacted her.

To actually be there and to have it be part of your experience and to see it and to feel it and to share it. All of a sudden it really hits home. It means something, it's real, it's not just a vague notion of what it would be. I think it opens your mind. (#9)

A fourth participant who talked about her college roommates who were Japanese and East Indian, summarized her learning this way.

I read a lot and have people tell me about things. . . but until I go out and actually see (people and places which are culturally different), it's abstract. But once you're doing it, and once you've done it, it becomes real. . . It's kind of like that "ah hah" moment. So this is the way it is! (#6)

You can almost feel the excitement that radiates from these words. These four students, and several other study participants, felt that this was the place of greatest learning - where they were able to meet and interact with people who are culturally different from themselves. This happened for some (4) of them when traveling outside of the country, while others interacted with people from diverse cultures during college or even growing up. Several compared personal experience with book learning. They all agreed that you could learn significantly through studying, but it was the experience of interacting with someone who is culturally different from yourself that truly made it real. This closely reflects the interplay between the classroom and fieldwork experiences during occupational therapy education.

In the literature, there were several authors who believed that self-awareness was the first step in becoming culturally competent (Chan, 1990; Harry, 1992; Lynch & Hanson, 1998; Weaver, 1999; Wells & Black, 2000). Likewise, in this study,

some of the participants also stated that an attitude of willingness was the primary characteristic. However, there were a few who spoke of the interplay between knowledge and willingness. Above, participant #9 spoke of how having cross-cultural experiences can open your mind. She went on to say,

> *I think it certainly helps to learn through books and to talk to people, . . . [but] I think your mind has to be open already to a certain degree before you get there. (#9)*

So, in this dynamic interplay, learning can open your mind to new experiences, but having an open mind also allows you to gain the most out of those experiences. Perhaps these two characteristics develop in a circular or spiral-like fashion. You might be taught to be an open-minded person with an accepting attitude and a willingness to try new things. This might lead you to learn about other cultures through a variety of methods. Your open mindedness supports your learning, allowing you to get the most out of the learning experience, and that knowledge then increases your understanding and further enhances your attitude of acceptance.

The students in the study experienced this in a variety of ways. Some had little knowledge but experienced a cross-cultural interaction that increased their awareness and subsequently caused them to seek a greater understanding of the culture through research and study. Others had received some formal training in diversity and cross-cultural interactions which opened their mind somewhat so that they were more prepared for a cross-cultural experience. This experience increased their awareness and understanding even further, and led them to more study and more experiences. The dynamic interaction between the first two characteristics of knowledge and a willing attitude, is unique to each person who is part of the process. But as one author said, (McPhatter, 1997) knowledge and awareness is somewhat useless unless you put it into action. That leads us to the third major attribute that emerged from the data; culturally competent people practice particular **behaviors** with one another.

Behaviors

The study participants identified several common **behaviors** that are observable during competent cross-cultural interactions. These include:

1. active engagement,
2. appropriate communication skills,
3. behaviors other than communication which may involve compromise and change.
4. client-centered care and the importance of being aware of and responding to context.

Active Engagement

Being culturally competent is not a passive role you play. The participants made it very clear that it involves active engagement. You have to do something. One student said that *just trying to do* (#1) something is being culturally competent. For example, she tried to speak Spanish to an Hispanic client; she bought a book in order to try to educate herself about her own culture; she tried to talk to people who were culturally different than herself. In each of these instances, she attempted to do something. She didn't just sit back and let things happen to her. Another student echoed this notion by using words like

[You] get out there. . .

. . . really get your foot in the door

. . . you keep going and going

. . . make a point of going over, of approaching them

. . .make the effort

. . .you have to thrust yourself in there. (#3)

It's important to take the initiative during cross-cultural interactions according to the study participants. A culturally competent person must take action. Because all of the study participants are White women, I wonder if this might be a response of

the dominant group when interacting with those who are non-dominant. This concept will be further explored in chapter five.

Communication Skills

Many of the behaviors a culturally competent person engages in involve appropriate communication skills. This was a theme that was present in every interview, and many participants spoke about the importance of asking questions as a means to engage the other person in discussion, and a method for gaining information. This is an interesting point, since many in the United States were taught in childhood that it is impolite to ask questions of others, and many other cultures also believe asking questions is impolite. Yet the study participants spoke of the importance of doing just that. Many of them spoke about the importance of asking questions for clarity.

> *I think [asking questions] is a very important part. I think that's the only way that you can really understand what somebody's saying and what they're trying to get across to you. (#4).*

When relating her experience of observing a White occupational therapy practitioner interacting with an East Indian family, the student above was impressed with the therapist's ability to communicate. The therapist didn't assume to know why the family interacted in a particular way, instead her approach was

> *. . . asking questions and trying to understand what their cultural norms are, and what their experiences have been. (#4)*

A study participant who is Jewish related the story of a man who was asking her *ridiculous questions* about being Jewish. She didn't mind answering him, however, because

> *. . . he was trying to know. He was taking time to learn more about me. . . he didn't just judge me. He wanted to make sure. (#1)*

This is another important point. You may ask *ridiculous questions* because you know very little about a certain culture. But if you are sincere in the asking, if you

truly are interested in knowing more, most people recognize this and will attempt to tell you what you want to know. Again, this suggests that you must be comfortable in allowing yourself to be vulnerable. Asking ridiculous questions can be humiliating, but according to the study participants, it is important to ask.

The other aspect of asking is to listen well. Many students talked about the importance of listening. During cross-cultural interactions, listening is an active, rather than a passive process. One student used her listening skills to learn about a Haitian client, and then *verified what [she] heard her saying* to make sure she was understanding her correctly. The client was in a work readiness group, and she was trying to let the student know that in her culture it wasn't important for her to get a job. The student listened well and then changed her goals with that client. She went on to say how their interaction improved because "*I was listening to what she was saying and respecting that." (#6).* This notion of listening well is strongly supported by Delpit (1995) who writes about "a very special kind of listening, listening that requires not only open eyes and ears, but open hearts and minds. Both sides do need to be able to listen, and I contend that it is those with the most power, those in the majority, who must take the greater responsibility for initiating the process." (pp. 46-47). The participants in this study seem to agree with Delpit.

Sometimes communication with another person is hampered if they speak a language that you don't know. Although several participants suggested that learning and speaking a few words of the other person's language is important to help develop rapport and demonstrate respect, many addressed the issue of finding translators for people who do not speak English in a clinical setting. This is vital if there is to be any true understanding between yourself and your clients. Several students talked about experiences where adult family members of the client were sought out to help with the translation and understanding for the client. One student addressed the proper way to use a translator.

> *If I were working with a family who didn't speak English, and if there was an interpreter there, I think the ideal interaction would be for me to talk directly to the family, not the interpreter, (#8)*

The emphasis here is to address the client in a respectful way, rather than to talk only with the interpreter. She went on to say,

> *. . . but I think speaking and making eye contact with the family, (helps them) feel that they're included and an active part of the discussion, They're the ones that I'm trying to communicate with, not the interpreter. (#8)*

Another student added:

> *. . . we did have an interpreter. . . but you were very aware of your body language because that's how you were talking with the people. (#9)*

Both of these students and others addressed the importance of observing the person's body language as part of effective communication. An aspect of learning about the person's culture is learning the meaning of their gestures and other non-verbal patterns such as eye gaze or physical contact.

Communicating well and effectively is vital in order to reach an accurate understanding between yourself and someone who is culturally different from yourself. Sometimes non-verbal messages are misunderstood, and questioning for clarification is necessary. One participant reported her observations of a clinical interaction. While interpreting the head nods by people from Southeast Asian cultures

> *. . . the therapist went ahead and really probed more with questions to be sure that they understood. They really didn't and they were just trying to be polite and not rock the boat, so I think if it's done in a respectful way, that further probing, to make sure that the client . . . really understands what the therapist is getting at and making sure that it's what they want as well. (#8)*

Understanding, or *getting through (#4)* to people from a variety of cultural backgrounds is not only a goal in cross-cultural interactions, it is also an outcome of effective communication. Students in this study often spoke of other means of communication that they've observed. They spoke of therapists who speak clearly

and slowly and wait patiently for a response. Some therapists demonstrate what they want done, or if trying to more clearly understand their client, will ask the client to demonstrate what they mean. Some use humor to break the ice such as demonstrating what they want in a silly way, or purposely mispronouncing words in the client's language to make them laugh. Another had his client teach him one new word of her language each time they met. The purpose of all of these methods is to gain a greater understanding and rapport between the client and practitioner in order to provide culturally competent care.

Client-Centered Care

Within a clinical or practice context, some of the participants spoke about the importance of client-centered care (a concept discussed in occupational therapy by Law et al., 1996) and its relationship to cultural competence. They felt that you couldn't truly be client-centered without being culturally competent.

> *How could you do one and not the other? It seems kind of inherent just in the nature if you truly invest in and its truly client-centered, you would have to be culturally competent because that would be something you would be interested in getting to know about the individual. (#10).*

When another student spoke about being client centered, I asked her about its relevance to cultural competence, and she replied,

> *Well, I think it's really a key element. . . If [activities] are not something that is important to someone's culture then. . .they're not going to benefit from anything that you do. So, I think client-centered has to take into account someone's culture and the experiences that make life meaningful for them, and I think culture is a huge part of what makes life meaningful to people. You cannot have client centered care without being culturally competent. (#11).*

This is a very important point for occupational therapists. Although client-centered care is a vital principle of occupational therapy intervention, it has rarely been as closely associated with cultural competence in the literature, as these students make it.

Compromise and Change

Related to client-centered care was the concept of change. If you are considerate of the client's values and cultural beliefs, you are cautious about what you will try to get them to change for therapeutic purposes. One participant talked about the cultural custom in Rumania of keeping children in many layers of clothes, even when the weather was very warm. The supervising occupational therapist from the United States spoke to the Rumanian pediatric caretakers about this, but realized this was a custom that was not going to change. The student remarked,

> *I liked the way that she didn't try to change everything 'cause she realized that you can't really go in and change the whole system.... You can only change so much, so I liked the idea that she was willing to accept some things that they found very important to their culture, and yet trying to change as much as she can to help the children. (#9).*

Another perspective from another student indicated that you don't try to change other people at all. You're the one who needs to change. (#5). Others articulated a need to compromise. One participant was working with a Haitian woman in a group situation where the goals included developing work readiness skills. The Haitian woman did not seem to be interacting well, and upon further questioning the student realized that the woman had never worked nor was she planning to find a job.

> *I was in a position where it was my job to help her, and coming to a compromise was realizing that my helping her doesn't necessarily mean needing what I had in my mind as my goals.*

Kind of reformulating my goals as I went along. . .based on what she's telling me. (#6).

As a result of this awareness and willingness to compromise, the student and client developed mutual goals based on what was meaningful for the client, and therapy became much more successful for both of them.

Compromise also means recognizing your own values and beliefs, as well as recognizing the other person's, and then trying to find and work where there is *common ground*, according to this student. This sometimes means setting many of your own values aside in order to be responsive to the other person. Another student talks about it this way.

You have to find some area of compromise. Obviously it is situation-dependent. Like how can you take the situation where the client, because of a culture[al belief or custom], can't do this or won't do this, and how can I find some way of making it that they can accomplish what I need(ed) them to do and yet still fit in with their values and beliefs. (#10).

One example of this is a therapist who was working with a Somali child to develop right hand dominance to improve coordination. The child would not eat using the right hand due to the cultural belief related to using the right hand for toileting and the left hand for eating. When the therapist learned of this custom, she decided not to force the issue, but worked with the child to develop eating skills with the left hand, and other fine motor skills with the right. This example demonstrates that compromise, as articulated by the study participants is closely integrated with culturally competence and client-centered care.

Many participants in this study talked about how you should behave in a cross-cultural interaction. They also talked about behaviors that were inappropriate in that kind of setting. These included:

DON'T

judge people (#11), (#4)

avoid talking with someone who is different (#1)

refuse to engage with others (#1)

close your eyes and not deal with it (#1)

ignore difference (#1)

stop making an effort (#1)

be closed to new ideas or difference (#5)

assume (#9)

refuse to try to communicate with someone who doesn't speak English (#9)

forget to listen (#11)

fail to respect people (#6)

patronize (#8)

be intolerant or stereotype (#8), (#12)

be afraid to admit your ignorance (#12), (#3)

be impatient (#7)

be blind to non-verbal cues (#7)

stop learning (all)

give up (#3)

This lengthy list indicates that the study participants not only recognize culturally competent behavior, but are very clear about what you should avoid in a cross-cultural situation. Perhaps a close examination of this list is the place to begin as it would lead the learner to all skill areas of cultural competence including an examination of attitude, knowledge, and behavior.

Theme Three: Outcomes of Culturally Competent Interactions

The final theme that emerged from the data identified the various **outcomes of culturally competent interactions.** For the study participants these included an emotional impact, greater understanding of one another, collaboration and

connection, and ultimately, culturally competent care.

Collaboration and Connection

Many of the participants spoke about the sense of **collaboration or connection** that resulted from competent interactions with people who were culturally different. Two participants characterized this concept as *working together*.

> *I think that as we become more aware of. . . and learn about cultures, and they learn about us, we can work together. . . I think we really do have to work together in order to get anything done.. . .The point is, that if you know them and you can work with them, you can understand what's going on, then we can get together and solve some issues that we have in common. (#3).*

For this student, the end justifies the means, and *working together* is the main objective of being culturally competent, while, for participant #6, *working together* is an important process rather than the goal.

> *[It would] be important because it would have them working together on a common kind of goal that forces them to come together. It would be the best because they're working together.(#6).*

Other students refer to it this way.

> *If you can use all that information and come out of it feeling like you really connected with the people. . . I think that would be the best. (#7).*

> *The client collaboration [is what makes it best] because I really think that that's so important. . . I think client collaboration means what the individual wants. I just think client collaboration and cultural competence are the first things that are important to the individual and are crucial to health care. (#10).*

Greater Understanding of One Another

A sense of connection or a collaborative working relationship occurs because of the greater **understanding** that is achieved through culturally competent interactions. One of the definitions of *understand* in Webster's dictionary (1995) is *to know*. The participants recognized the importance of getting to know people from different cultures. It is interesting that when many of the participants spoke of understanding the other person, or understanding one another, they qualified the word to give it more emphasis. For example, they would say,

really understand

. . . trying to get a real understanding of what's making them \ feel the way they do or see things the way that they do. (#4)

. . .when the Black man tells a White person stories, the White person really understands it. [What's important] is increased understanding. (#1).

better understanding

If you have a positive cultural experience, maybe then you become more accepting and you get a better understanding. (#8)

Their use of emphatic words indicates to me that their perception of understanding someone who is culturally different means getting to know them at a deeper rather than at a superficial level. One student defines this as *cultural fluency* which she describes to be a deeper understanding than *the basic understanding of cultural competency.*

I think cultural competence has more to do with the basic understanding of what's going on. I think cultural fluency is understand[ing] the innuendoes, to understand the subtleties. . . (#3)

Positive Feelings/ Feelings of Comfort

Beyond the notions of understanding and connection, another thread that wove throughout almost every transcript of the interviews described the **feelings** of the participants during cross-cultural interactions. For the majority, these were positive. One emotion that was identified was that of feeling comfortable.

> *There's that sense of comfort that I felt was there. I think that you need to feel comfortable with each other in any setting whether it's just a cultural or just an interaction. For it to be successful and competent, you need to feel comfortable. You have to have that comfort. (#6).*

When talking about a group of culturally diverse college friends and her experience with them, one participant stated,

> *It was very comfortable. It was great. It was a supportive environment and I think that's what helped a lot in opening up. (#12)*

Relating a clinical experience that she observed, the same participant told of an elderly Egyptian woman who spoke little English. The therapist encouraged the family (including the grandchildren) to be part of the therapy session and to help him understand his client's needs. As a result:

> *The patient was happy. She was always smiling. It was very comfortable with her. It made it a more comfortable experience for the woman. (#12).*

Feeling comfort was identified in the pilot study also. Apparently, this is an important result for these participants, and it made me think about the awkwardness and discomfort that is sometimes present in cross-cultural interactions. It also made me wonder if this is a White/ privileged/ middle-class phenomenon. Would feeling comfortable be as important to someone from a non-dominant group? My supposition is that many non-dominant people in the United States rarely feel *comfortable* in a society that is viewed by them as hostile and oppressive.

Many other positive feelings were identified as well. Participants used words

such as the following to describe their culturally competent experiences.

> *It was wonderful. It was good. Very rewarding. Such a feeling of accomplishment. It was hard but it was also exciting and felt good. (#4).*

> *It felt good because I could explain it to him. So I was glad I could do that. (#1)*

> *Everyone is happy, laughing and having a good time. It's a positive thing. (#1)*

> *It was enlightening, a valuable experience. I felt more satisfied that maybe in the future I would be able to use (what I learned). Everyone was happy and satisfied. (#8)*

> *I think it feels wonderful. It makes you feel a little bit more worldly.(#11)*

> *I enjoyed it. It would make me feel really good about myself. I'd feel like I really accomplished something. (#10)*

These students described not only a sense of happiness and goodness, but many talked about a sense of success and accomplishment, a sense of competence. From the participants' words, It appears that acting in culturally competent ways is not only observable, but it can actually be *felt* by the person who has competent cross-cultural interactions. You know when an interaction goes well because you feel good about it. You can feel the pride of accomplishment and a sense of a job well done. What more can we ask for in our interactions with our clients and others who are culturally different from us. This is certainly something to strive for.

In contrast, the study participants also talked about the feelings that arose

from cross-cultural interactions that could not be characterized as culturally competent. In one example, a teacher was telling ethnic jokes to a culturally diverse audience.

> *In the bad [experience] something offensive was done. Somebody was offended. (#6)*

Another participant described an incident where a parent assumed a therapist was a gay man and refused to allow her child to be treated by him. This participant was quite upset with the injustice of the situation.

> *It makes me angry. I don't think anyone deserves to be labeled unjustly or inaccurately. . . If I were in that situation (above) myself, I would definitely be offended. (#8).*

From a Jewish woman who was told by an acquaintance that all Jewish people have money came these words:

> *It's like a slap in the face. It wasn't supportive at all. I wanted to get out of there right away. I didn't want to come back and interact with that person. (#12)*

From another whose friend was being maligned because he was gay:

> *I would get angry at the general stereotypes. When you hear the generalizations it makes me more defensive. (#10)*

And from another student who described the results of a client interaction with a therapist who had few cross-cultural skills:

> *The therapy was not client-centered. It was a waste of time, a waste of energy, and was frustrating. (#11)*

Other students used words like *resentment, I'd feel bad, feeling anxious, disappointing,* and *sad* to describe their feelings regarding negative experiences. The contrast in these words from those that described culturally competent interactions is clearly apparent. This is not the result we want from our interactions with clients, colleagues, acquaintances and friends who are culturally different.

All of the varied outcomes of culturally competent care that have been identified by the study participants emphasize the importance of cultural competency in occupational therapy client interactions. As occupational therapy

practitioners, our goal is to provide the best possible care for each of our clients. For those who are culturally different this can only happen through culturally competent care. The participants of this study have clearly identified the important attributes a person must possess to be culturally competent and the characteristics necessary for culturally competent care.

The thematic analysis above was necessary in order to construct the composite textural description which follows.

COMPOSITE TEXTURAL DESCRIPTION

The composite textural description is the synthesis of the individual textural descriptions. "The invariant meanings and themes of every co-researcher (study participant) are studied in depicting the experiences of the group as a whole" (Moustakas, 1994, pp. 137-138). These are then integrated to determine the combined themes.

The experience of cultural competence and culturally competent care occurs through an effort of will which takes time, work, and personal investment. As a person develops competence in cross-cultural interactions, she holds and responds to changing attitudes towards groups different from herself in a pattern that may or may not be developmental, but is certainly hierarchical. It is not clear whether one must move through these various levels in order to become culturally competent, or if she could begin at any level, but these attitudes include ignorance, and then move up to tolerance, openness to difference, acceptance and appreciation. Many study participants believe that a person must at least be at a level of acceptance when interacting with people who differ from themselves in order to achieve cultural

Participants related that in their experience, people who are culturally competent share certain attributes and characteristics. First of all, they <u>choose</u> to move in the direction of competence. This is a conscious and volitional decision, indicating a willingness to be self-reflective, to be open to others and their differences and similarities, and to maintain an attitude of respect towards others.

Secondly, they must be willing to learn about others and their culture. Some of the knowledge that must be sought includes knowing the values, beliefs, and customs of the culture, and particularly the specific beliefs of the person from that culture with whom they work. Although one can learn much of this information through formal and informal study, the participants identified the single most important way to gather knowledge about others is through personal experience with people who differ from yourself. Cross-cultural interactions can be, and often are, transformative in nature. One participant described it as the "ah hah" experience, where any previous knowledge gained from formal and informal study not only gets explored and challenged, but where one gets to practice cross-cultural behaviors. This is what makes personal experience so valuable. This experience can be gained through international study, through field trips across town, or by interacting with family and friends who are in some way culturally different from yourself. Students describe the opportunity to meet and interact with these folks as invaluable to their learning and the development of cultural competence.

The final characteristic of cultural competence is the practice of certain behaviors. One main point made by the majority of the participants is that being culturally competent is an active process. You must actually do something. Most learned through their experiences that they had to take the initiative in interactions, particularly being from the societally dominant group. You must *thrust herself out there* in an effort to connect with another person, and be willing to make yourself vulnerable, and you must do it time and time again. Acting in a culturally competent manner is a commitment.

Some of the particular behaviors noted and experienced include communicating effectively, using both verbal and non-verbal skills. If a person speaks a language other than English, it is vital to find an interpreter so that communication can occur. In addition, culturally competent interactions and care may include adapting the way you usually do things in order to accommodate the other person's beliefs and customs. Compromise often provides a satisfactory result. Changing a treatment goal to one that meets the interests or cultural beliefs of the

client is one way to compromise. The study participants believe that culturally competent care is a necessity if client centered care is the goal.

The study participants identified important outcomes of culturally competent interactions. These include feeling a sense of connection and collaboration with the other person, which contributed to further positive interactions and an ability to work well together. Additionally, they talked about feeling comfortable in cross-cultural situations. For them, this sense of ease and comfort with one another was an important result of effective and competent interactions. They also spoke of a sense of satisfaction about the process and a feeling of success that provides the internal feedback that the experience can be identified as being culturally competent. In summary, the study participants believed that although becoming culturally competent and providing culturally competent care takes commitment, time, and work, it is well worth the effort.

COMPOSITE STRUCTURAL DESCRIPTION

The composite structural description is constructed from the individual structural descriptions to present "a picture of the conditions that precipitate an experience and connect with it" (Moustakas, 1994, p. 35). This is a way of "understanding *how* the co-researchers (study participants) as a group experience *what* they experience" (p. 142).

The perception of cultural competence and experience with culturally competent interactions and culturally competent care is influenced by the study participants' ability to self-reflect, by their personal experience with people who differ from themselves and by their own racial or cultural background. Those who were self-reflective seemed to be further developed towards cultural competency. Reflection of themselves as cultural beings seemed to lead this group of participants to be more sensitive to, and willing to learn more about, those who are culturally different from themselves.

Although learning about diversity through formal educational processes is

useful, it is the opportunity for personal interaction that provides transformational learning that has most meaning to the students and changes their perceptions. Although all participants state that it takes hard work and commitment to become culturally competent, and all could recognize culturally competent care when they saw it, many did not feel that they had yet achieved that status. However, those who had experienced numerous cross-cultural interactions approached new opportunities with openness, excitement, wonder, and a kind of fearlessness that allowed them to not only initiate interactions, but to *thrust themselves out there* over and over again, if necessary, to make connections with those who are culturally different. About half of the participants (5 out of 11) exhibited highly developed self-awareness and were confident enough to put themselves in a position of vulnerability where they might make cultural mistakes or be rejected. However, for these participants, the joy and wonder of learning about others was worth it.

The other six participants who had had fewer personal experiences were open to learning about others but more tentative in their approach. They often spoke about growing up in neighborhoods where there was little diversity, which they felt was a barrier to learning about others. But by moving to an urban area, or taking courses about difference, or meeting culturally diverse people in college or while traveling, their knowledge grew and their attitudes changed. For these participants, moving towards cultural competence is an important goal, particularly as health professionals, but the journey seems more arduous for them. There was little of the joy and wonder expressed that was seen in the participants with the greatest experience.

Although all study participants were Caucasian, two self-identified as Jewish. For one of the Jewish participants, her culture/ethnicity certainly influenced her experience with cultural competence, as she described being oppressed and different from the majority of her friends. She related how she could better understand and empathize with those who were culturally different. The other Jewish participant did not demonstrate any particular sensitivity towards others, however, nor did she seem to be more developed in cultural competency given her

culture/ethnicity.

Therefore, given this small sample of participants, no definitive or generalized statements can be made regarding one's own minority status and its relationship to the development of cultural competence. The main difference between the two Jewish women identified above was their ability to be self-reflective. I believe this attribute contributed significantly towards their development of cultural competence. One concept that may have been more closely related to racial identity and majority status however, is their willingness to allow themselves to be vulnerable in cross-cultural interactions (mentioned above). Being part of the privileged majority allows us to take more risks, because there is a greater sense of safety. The study participants may be reflecting their privileged status as they talk about initiating action, thrusting themselves out there, and committing to do that time and again even if rejected. Only someone who feels quite secure in herself and her world would feel free to interact in that way.

TEXTURAL-STRUCTURAL SYNTHESIS
(The Essence of Cultural Competence)

The final step in Moustakas' (1994) methodology is to integrate the composite structural and composite textural descriptions, "providing a synthesis of the meanings and essences of the experience" (p. 144). The essence of cultural competence, as perceived by the study participants, is stated below.

Culturally competent interactions are clearly recognizable from those that are not. Likewise, people who are culturally competent are readily apparent as well. Additionally, there is a range of attitudinal levels which people have as they move towards cultural competence.

The first level, **ignorance**, often occurs when people have had no personal experience with others who are culturally different from themselves. Usually, there are few people in their lives who model cultural sensitivity or cultural competent behaviors, and the news and other media offerings tend to solidify stereotypes of

different groups of people that are common in the dominant culture. At this level, people make erroneous assumptions about others based on these stereotypes, have little cultural self-awareness, and little openness to or interest in learning about others. This level could be considered **Cultural Incompetence.**

Tolerance towards culturally different people is an attitude that someone adopts because of a beginning awareness of difference. It closely allies with a sense of being "politically correct" (in the more negative understanding of the term)(Wilson, 1995), in that a person feels that they should try to be nice to someone else. Although a person who is tolerant of differences is aware of *not being disrespectful,* It is a more superficial attitude that does not yet move a person to acceptance of people who are culturally different.

The next attitudinal level is an **openness to difference** which is a hallmark disposition of **Cultural Sensitivity.** Being culturally sensitive means not only being aware and open to difference, but also recognizing that difference is an important factor, especially to the person who is culturally different. At this level, people can recognize the uniqueness and the strength of that difference, and are generally interested in learning more about others.

Openness to difference is also seen with **Cultural Competence,** but it is the attitude of **acceptance** that is the hallmark at this level. Although people who are culturally competent may or may not pass through the levels identified above, it is clear that they share certain attributes. Not only do they respect and accept others, they are aware of and accept themselves as cultural beings, and share a **willingness** to reach out to others. Being culturally competent is a volitional act. People choose to initiate cross-cultural interactions, and are willing to place themselves in a position of vulnerability in order to learn more about, and interact with others. Having the confidence to do this may be more of an attribute of privileged Whites, who may be more secure in US society than those who are non-dominant. Culturally competent people are also **knowledgeable** about themselves and others or actively seek knowledge in order to improve their cross-cultural interactions. Although learning may occur through more traditional formal (academic classes and

workshops) and informal (self-study, novels, movies and other media) means, the learning activity that is most meaningful and transformational is the actual personal experience of interacting with someone who is culturally different from oneself. It appears that the more positive cross-cultural interactions one has, the more one is motivated to learn about, and interact with others, and the more skilled they become. Specific **behaviors** are also apparent in people who are culturally competent.

Although it is important to be open to others and willing to interact, as well as to be knowledgeable, it is only with the development of specific skills and/or behaviors that one is actually culturally competent. People cannot be passive participants in this process but must **take action.** They must **do something.** Active engagement is often demonstrated by using respectful communication which includes asking questions to clarify and to learn, listening well, paying attention to non-verbal cues, and sometimes employing an interpreter. Within culturally competent care, communicating well may include all of the above as well as speaking slowly and distinctly, waiting patiently for the response, demonstrating what you want the client to do, or having the client demonstrate for you. It may also mean using humor which is shared or self-deprecating.

Another behavior observed during culturally competent care may include the therapist changing the way she typically practices in order to accommodate the values, beliefs and wishes of a culturally different client. For example, the occupational therapy practitioner may completely change her goal of teaching an elderly Italian man how to dress, when she learns that the women of his family believe that it is their duty and privilege to take care of him in that way. Listening well to what the client wants and working together towards those goals is effective client centered care. True client centered care cannot occur with culturally different clients without culturally competent care. Compromise is also seen during culturally competent care. Oftentimes the client and the practitioner must work together to arrive at an intervention goal or solution that incorporates behaviors that reflect the client's beliefs as while providing the most effective therapeutic interventions. For example, an infant with low muscle tone will develop a stronger back and improved

erector muscles if lain prone on a firm surface. However, a Navaho custom is to always place the child on a pillow when on the floor. Because a goal of both the practitioner and the family is a stronger and better-toned baby, the therapist may relax her own recommendations about resting positions and help the parents find other play activities that will strengthen the infant's back musculature, and/or the family may agree to lie the child prone without a pillow for a certain time period each day.

The results of culturally competent interactions and care include greater understanding between people, which leads to stronger connections or rapport and increased collaboration or the ability to work together. Emotionally, the participants in this study talked about being more comfortable around others, and achieving a sense of success and accomplishment with these positive interactions. These reactions may be due in part to their privileged status within the society. It is not known whether people from other non-dominant groups would identify the same feelings and reactions.

Although cultural competence is often the goal of people who want to experience effective cross-cultural interactions, perhaps surprisingly, it is not the ultimate level one can achieve. Another level identified as **Cultural Fluency** is characterized by the attitude of **appreciation.** Becoming culturally fluent is achieved by only a few, and happens if one has significant experience, such as an immersion experience, with a cultural group. By having intimate knowledge of a group of people and their beliefs, values, customs, and language, one can appreciate, understand and respond to the subtleties, the unwritten rules of conduct, the colloquialisms of the language, the innuendoes, and the unexpected in an effective manner.

In summary, cultural competence is perceived of by these study participants as an objective that occupational therapy practitioners must strive for in order to offer client-centered, appropriate care to their clients. However, it takes time, commitment, and hard work to achieve. But as the participants in this study who have experienced culturally competent interactions have averred, it is well worth the effort.

CHAPTER 5

SUMMARY, FINDINGS, IMPLICATIONS, & OUTCOMES

Moustakas (1994), describes the final chapter of a phenomenological research report as a summary review of the study where "the researcher returns to the literature review and distinguishes her or his findings from prior research, outlines a future research project that would advance knowledge on the topic, and discusses the outcomes of the investigation in terms of social meanings and implications as well as personal and professional values" (p. 155). He adds, "Development of a summary section of transcendental phenomenological research is an important challenge. If offers a kind of abstract of an entire investigation and in a brief span of material enables other researchers to determine its relevance to their own research pursuits and whether or not to review the entire research report" (p. 156). Within these guidelines, Moustakas includes the following in the final chapter: a summary of the study, comparison of findings to the literature (the discussion section), limitations of the methodology and of the study, implications, future research, and a "brief, creative close" (p. 184). This chapter will follow the guidelines outlined above in an attempt to meet that challenge.

Summary

Initially, I began this study to try to determine whether occupational therapy students who had received education that included diversity and multicultural content in their curricula saw themselves as developing cultural competence. This question arose from my own experience as an occupational therapy educator who was attempting to reach that goal. Recognizing the changing demographics and increasing diversity in the United States, I knew that occupational therapy practitioners needed to be culturally competent in order to offer client centered care to the recipients of their services. I had been introducing and integrating the concept of

culture and its impact on occupational choice within my own courses for years, but my increased interest in and study of cultural competence led me to realize that I needed to do more. As I revised my own curriculum, I wondered about the impact of these alterations. What was the outcome of my teaching and how did it effect student learning?

As I began the literature search on the concept of cultural competence, I was led beyond the field of occupational therapy, which has limited resources, to other health-related disciplines, namely nursing, social work, and counseling psychology (chapter two). I examined what the literature had to say about the characteristics of cultural competence, educating for cultural competence, and the related outcome research. During this process, I recognized the need to explore students' perceptions and experiences as a way to evaluate how they understood the concept of cultural competence. There was a plethora of empirical studies, but a lack of student voices or personal responses in the literature, and I decided to begin to fill that gap with my own research. I chose to use phenomenology as a methodology, and after examining some of the literature on that subject, I decided to use the method outlined by Moustakas (1994) (chapter three). I realized at that point that my dissertation study would not be a traditional outcome study of occupational therapy curricula as I had first imagined, but I projected that I would gather data that would inform educators in important ways.

I determined that I could, yet should not, examine the students that I was teaching for my dissertation study. Not only could I not be objective, but as director of the occupational therapy program, there was a power differential between myself and my students that would likely interfere with the way students responded to me during the selection and interview process. I did complete a pilot study on two students in my program, in order to practice using the methodology I had chosen. I then sought out, selected, and interviewed twelve occupational therapy students from two urban universities in the Northeast. Data was analyzed only on eleven of these students, however, as the audio tape for the twelfth person was lost by the transcriptionist I had hired, and I had not made a back-up tape.

Data analysis (chapter four) followed Moustakas' guidelines and culminated in a composite description of the essence of cultural competence as perceived by the study participants. Within the analysis, however, the following three findings emerged from the data.

1. Students perceived a hierarchical framework of attitudes for cultural competence that corresponds with a cultural competence continuum outlined by Cross et al. (1989) (described earlier in this paper).
2. Students identified the essential attributes of cultural competence that I subdivided into three sub categories,
    a) an **attitude of willingness** that emphasizes the importance of a volitional act
    b) **knowledge** of self, others, and the social-cultural-political world within which they live, and
    c) **behaviors** that are learned through cross-cultural experiences.
3. Students identified the outcomes of culturally competent interactions.

As I complete the data analysis, I recognize that the findings do not specifically evaluate the occupational therapy curricula from which the study participants come. I did not try to correlate curriculum with the responses of the study participants but took a broader view that included their education as one aspect of their experience and life history. However, as I earlier surmised, the findings are and will be important for occupational therapy educators. Teaching for cultural competence is vital. By understanding how students currently understand the phenomenon, educators can strengthen their teaching in this area to offer students what they need to begin to develop competence in cross-cultural interactions. The following sections of this final chapter will provide a discussion and implications of the findings, a critique of the research methodology, and suggestions for further research in the area of cultural competence.

Discussion of Findings and Implications

The essence of cultural competence defined by the participants in this study did correlate in many respects with concepts found in the literature. They identified certain attitudes which seemed to fit within a cultural competency continuum identified by Cross et al. (1989), and also identified essential characteristics they perceived in a culturally competent person. These fell into three subgroups and were quite similar to those identified by numerous authors as awareness, knowledge and skills (Kavanagh & Kennedy, 1992; Lynch & Hanson, 1998; Pedersen, 1988; Pedersen & Ivey, 1993; Wells & Black, 2000). The study participants, however, emphasized certain characteristics and expressed some major differences from the information found in the literature. It will be those that I will discuss in this section.

Willingness: The Volitional Aspect of Cultural Competence

One of the most intriguing findings from this study was the notion that being culturally competent is a choice. One must be *willing to* assert herself into a cross-cultural situation. Participants talked about a *willingness to: seek out* and *to find out (#3), to learn, accept and experience (#4), to listen and understand (#2), to be open (#6), to let go of our assumptions (#3),* and *to admit you don't know anything (#6).*

Volition

Having the will to do something connotes having and making a choice. Choosing to participate in cross-cultural interactions is a volitional act. It is important, therefore, to examine the concept of volition as part of this discussion. Gary Kielhofner is an occupational therapy theorist who has developed the Model of Human Occupation, a theoretical practice model and frame of reference for occupational therapy practitioners (1997; 2002). Because he has written quite extensively about the concept of volition, and because his work is so widely

respected within the profession, I will use his ideas to guide my thinking and discussion.

Kielhofner conceptualizes volitional thoughts and feelings as pertaining "to what one holds important (values), perceives as personal capacity and effectiveness (personal causation), and finds enjoyable (interests)" (p. 44) Volition results from the dynamic interplay between these three.

Values

"Values refer to what one finds important and meaningful to do" (Kielhofner, 2002, p. 15). Personal values often develop from societal and family values. At this point in US history, being sensitive to and having skill in cross-cultural interactions is a developing societal value, particularly for the educated. It is expected that an educated person will at least be "politically correct" or culturally sensitive in their interactions with one another. Herbst (1997) defines the term "politically correct" in the following way.

> *Politically correct* describes the efforts of those seeking to deal politically with such social and political issues as (1) bias related to race, ethnicity, religion, sexual orientation, gender, and age; (2) prejudice against the physically or mentally impaired or those of a stature outside the perceived norms; and (3) neglect of the natural environment. . . . A main goal of those involved with such issues has been to advance the principle of equality. (p. 183).

I am using "politically correct" in the way Herbst defines it above, even though I am aware of the conservative backlash to the term and the societal movement related to it (Wilson, 1998). Because of the increased awareness and sensitivity to difference, many people in the United States realize they should not talk about other people in a denigrating manner. However, even after adopting that societal value, and with the knowledge of what not to say, many people are still at a loss when it comes to the appropriate way to interact with those who are culturally different .

Related to these societal beliefs, the American Occupational Therapy Association has developed a Code of Ethics and a statement of core values (Kyler, 2002) that include the group's beliefs and values related to diversity issues. These documents guide occupational therapy practice and education. However, even though there may be societal and group expectations for certain behaviors, not everyone within a particular group will actually adopt the values or behaviors associated with a particular group. Not every occupational therapy student will choose to become culturally competent, despite the expectations of the professional organization. As a point of interest, not one of the study participants mentioned the Code of Ethics of the American Occupational Therapy Association, although I am sure that they have all been introduced to it because it is mandated in the accreditation standards of the profession.

However, many of the participants in this study expressed the ways they valued cultural competence and culturally competent interactions and care. When questioned about a competent clinical interaction that she described, where the therapist respectfully questioned an Asian family whose body language was hard to understand, one student (#8) stated, *I think it's a valuable experience.* When asked why, she stated, *I felt satisfied that I got something out of it.* For this participant, what was important and meaningful to her was the fact that she was learning from the experience.

Others talked about particular values they learned as children. Participant #10 stated

> *It's how I was raised and the values I was taught [such as] to appreciate and be open minded to everyone, and [that] people are individuals.*

She demonstrated this value by *taking the time to get to know someone* rather than close herself off to those who were different than she. She went on to apply this particular value to a clinical setting, stating that it is important *to take the time to pay attention to someone...and treat them like the person they are, aside from their diagnosis.*

In a similar vein, participant #11 spoke about the values she was taught from

her family. *I've been brought up with the understanding that there's a variety of ways to live and no one way is the right way.* For both of these participants, the values they learned early in life have contributed to their choice to develop cultural competence.

Not all participants attributed their values to what they were taught as children, yet they did clearly speak about what was important and meaningful to them. Many identified how they valued being open minded. The words of participant #10 are reflective of many of the others.

> *I think it's extremely important to open yourself up to new experiences, and have an open mind to find out about something before you judge it or ignore it (#12)*

Some talked about the importance of respecting others. *Being who I am, I tend to respect people...you show your respect in different ways. (#6).* Many identified how important it is to learn about others. During the interview, study participants were asked to describe the best cross-cultural interaction they could think of. When asked what made this particular situation the "best", one participant replied, *Openness to learning and a lack of ignorance (#12).* Another student who felt that learning was key, expressed it this way, *Knowledge is power, essentially. A lot of times people aren't at fault [when they make cross-cultural mistakes]. It's just that they've never learned any different (#10).*

Many other values were expressed by the participants of this study. However, these examples of how they valued being open-minded, respecting the uniqueness of individuals, and learning about others support Kielhofner's (2002) premise that one's values contribute to their volition. These concepts are important to the participants listed, and will positively influence them when given a choice whether to move towards cultural competence or not.

Personal Causation

Personal causation correlates with a sense of personal agency and relates to

an awareness of how effective one perceives herself to be when interacting in her environment. Kielhofner (2002) identifies two dimensions of personal causation.

> The first of these dimensions , **sense of personal capacity**, is a self-assessment of one's physical, intellectual, and social abilities. . . The second dimension, **self-efficacy**, is the thoughts and feelings one has concerning perceived effectiveness in using personal abilities to achieve desired outcomes in life. . . ; that is, we feel more able to control outcomes in certain circumstances than in others. Persons who feel capable and effective will seek out opportunities, use feedback to correct performance, and persevere to achieve goals (p.46).

How does this apply to the idea of someone choosing to engage in cross-cultural interactions? I interpret Kielhofner's definition to mean that someone must have a positive awareness of herself as a sociocultural being who has the confidence to approach others and learn from that interaction. If that confidence has not developed from childhood, it may result from incidental interactions. An example from the data is the story one participant shared during her interview. She related that she had feared African Americans because she had had little contact with them, and had learned negative stereotypes from the media. She not only was not confident in her interactions with African Americans, she actually was afraid to interact with them. While waiting at a bus stop one day, a young Black man came up to her and told her he liked her shirt. She became frightened and moved away. He courageously followed her and gently told her that he only wanted to compliment her on her shirt, and then he walked on. Her response was,

> *although I felt silly, it really helped me out. It was very brave of him too. He didn't have to do that, but in a small way, he had educated me; at least enlightened me on my ignorance. And that is always the first step. (#3).*

This was a defining moment for this participant, moving her to evaluate her personal assumptions and causing her to begin to learn about others. Using Kielhofner's terminology, she used the feedback provided by this stranger to correct her performance, and went on to relate her later success with cross-cultural interactions.

Although this participant believes she still has a lot more to learn, she does feel that her interactive skills are much more effective than those she possessed with that initial interaction. Her sense of personal causation has improved.

Another student described a school trip to Paraguay where the team she traveled with had an opportunity to work with children and their parents on dental hygiene. She didn't speak the language and knew little about the culture entering the project, nevertheless, the experience resulted in very positive outcomes.

> *I think the fact that we were able to communicate and click, and get through to people who have come from such a completely different background. . . [This made it] a wonderful experience. It is also such a feeling of accomplishment.*
> *(#4).*

This participant's sense of efficacy was quite high as a result of this positive interaction, even though she had initially evaluated her personal capacity (inability to speak the language, knowledge of the culture) as low. The positive experience resulted in a strong sense of personal causation.

It seems then, that the more one has the opportunity to interact in cross-cultural situations, learn from them, and alter one's behavior, the better is one's sense of personal causation in a multicultural world.

> *Just having that positive experience . . . set the stage so that I'd be comfortable in other situations where I'm interacting with a person who's different than I am (#6).*

This supports the importance of providing cross-cultural experiences which will be discussed later in this chapter.

Interests

The third component of volition is one's interests. "Interests are what one finds enjoyable or satisfying to do" (Kielhofner, 2002, p. 53). They can be simple pleasures such as making cookies for a grandchild or one's grand passion such as

composing a symphony. Enjoyment from a task may arise from sensory pleasures, from intellectual fulfillment, from aesthetic satisfaction, or a "sense of association and fellowship experienced" (p. 55) when interacting and doing things with others. Being interested in something means we prefer to do that task over some others. It allows us to make a choice based on that preference (Kielhofner, 2002).

The study participants often spoke of the enjoyment of interacting with someone who is different from themselves. When asked what an overseas experience was like for one participant, she replied. *It felt good. I remember being very excited (#4).* Another student related her experience working in a Japanese company with several Japanese co-workers. *I enjoyed it. I had been with these people for a long time so I was very comfortable with them (#7).* When describing her experience with the deaf culture and with friends who are East Indian, a third participant expressed her feelings this way. *I think it feels wonderful. It makes you feel a little bit more worldly (#11).* For this participant, some of the enjoyment she felt from this experience came from her sense of increased sophistication and knowledge which broadened her world view. These words clearly demonstrate a feeling of enjoyment shared by these participants, which according to Kielhofner (2002), contributes to their interest in cross-cultural interactions.

Kielhofner (2002) believes that it is the dynamic interaction between one's values, interests, and sense of personal causation that contributes to a person's volition. This notion was evident in the participants from the way in which they described their experiences. The data analysis of this study indicated that the participants valued effective cross-cultural interactions, although two of them talked about it as an emerging, not a realized, value for them. Furthermore, the majority of the participants indicated that their sense of personal causation was enhanced by their cross-cultural interactions, and that these experiences were enjoyable to them and piqued their interest. All of these factors contribute to their motivation to choose to interact with people who were culturally different from themselves.

Levels of Willingness

Kielhofner's (2002) concept and discussion of volition contributes to the realization that being willing to, or choosing to embrace the attitudes, knowledge and skills to become culturally competent is a complex task. His theory helps us to understand what volition is and how this might occur. It doesn't, however, enlighten us as to why the participants in this study often talked about the concept of willingness. Did everyone in this study demonstrate the same level of willingness, or talk about willingness in the same way? The answer to the question is no. As I interviewed and then read and reread the transcripts of the interviews, I found myself thinking, "She really gets it" or "She's got a ways to go." I believe that part of my personal assessment was based on the way participants talked about their reasons for choosing to be part of these activities.

Non-reflective Willingness

Sometimes people choose to behave in a particular way because it is what is expected of them. With the increase of "political correctness" (PC) in the mid-eighties (Wilson, 1998), and an increased sensitivity to difference, many people recognize the need to use inclusive and less disparaging language than was used in the past when talking about people from non-dominant groups. With an increased sensitivity to diverse groups in this country, people are often taught not to be disrespectful of one another. But like other kinds of learning, some people behave and respond to the lessons by rote, not really thinking about why they behave in this way, or really engaging in the learning in an active way. These people choose to interact with others effectively because they're 'supposed to' or they feel like they should. They are 'doing the right thing' not because of any internal drive, but because of external societal expectations. I call this level of willingness **nonreflective willingness.**

Only two or three of the participants in this study demonstrated this. One

participant was telling the story of someone who was telling ethnic jokes. When I asked her what was wrong with this she said,

> *You're supposed to respect other people. . .and part of being a professional is respect for others and their differences, especially when you're a teacher (#6).*

This participant recognized that the expected behavior of a professional is to respect others which means that you don't tell ethnic jokes. She had learned that lesson well. But she did not add anything else that might have indicated that she had an internal awareness of the oppression, injustice and hurt inherent in such an act. This participant would perhaps choose not to tell this kind of joke, but her decision might be grounded only in the expected behavior of someone in a professional role.

Non-reflective willingness.

Another participant was talking about how she might react to someone from the Middle East.

> *I don't pretend to know more about the Arab countr[ies] but I know women aren't treated as well and are expected to obey the men. So I accept that. Over here I would [accept that behavior] too, especially if I was working with them [in a clinical setting]. You know, I'm not going to change it, [but] I don't have to respect it. (#5).*

This kind of cultural relativism is another way that some show non-reflective willingness. This student has learned the concept that each person has his or her own culture which should be respected as unique, but she hasn't reflected on the moral or ethical conflicts that might arise from some cultural practices or customs.

Students at this level of willingness are moving in a positive direction, but have much more work to do to truly develop a level of cultural competence that emerges from their own personal values. At this level, people may have quite a bit of cultural knowledge but still need to develop the areas of self-awareness and skills.

Cautious Willingness

Approximately six students demonstrate a willingness to learn and behave in more competent interactive patterns, but are still hesitant, either being afraid to make mistakes or lacking the confidence in their abilities. This level of willingness I have labeled **cautious willingness.**

> *I think I am not as culturally competent as I would like to be because I don't know more about what it means to confront the difference. . . 'cause I don't know enough about the difference, the minority, the different cultures. (#1).*

Although the participant above is unsure of her ability and her knowledge, she later indicated that she had a clear understanding of power and inequality, and issues of difference. She also exhibited some beginning skill in cross-cultural interactions when she reported her interaction with an African-American man at a party.

> *I didn't know him very well. Everyone else was White. I asked him "Do you feel funny that you are the only Black person?" I didn't know if that was an appropriate thing to ask him or not. And he said, "Yeah." (#1)*

She went on to add that she may be more empathic because she is Jewish, and she is often in the minority as well. This woman had a significant amount of awareness and sensitivity, as well as knowledge, but was somewhat lacking in skill. She needs more practice with cross-cultural interactions to improve her skill and confidence, but is making good progress towards becoming culturally competent. She chooses to interact with others because of an internal drive to connect, and an interest in others. This is a very different level of functioning than that of unreflective willingness. The majority of the study participants seemed to be at the level of cautiouswillingness.

Committed Willingness

The final level of willingness is what I term **committed willingness.** These

are the participants who are not only willing to interact with others, but seek out opportunities to do so. They realize that they may make cultural mistakes and that they still have a lot to learn, but are eager to work with differing cultures and to learn from their mistakes. They have a 'bring it on!' mentality that is contagious. Listen to some of the words of these participants.

> *It's like accomplishing [something]. Look what I've come from. Look what I've learned. This is what it has been preparing you for. Oh, wow! There's a sense of excitement because you realize that there's so much more out there than just. . . backing away. That's the beginning. That's opening a door to a whole new world. (#6).*

Another expressed it this way.

> *[Experiences] are exciting, and good, and hard, too. For myself, traveling and meeting other people . . . are the best thing. I feel like I grow and have become who I am by knowing people with different experiences. A lot of stuff I've done in my life I never would have done if I hadn't met people who were different than me. (#4)*

And, yet another.

> *You have to be face to face with the person . . . on a daily basis. That's what I mean by exposure. You have to thrust yourself in there. You may get the door slammed in your face, but then you try again. You keep going and going. If you are willing, if you really are committed to understanding their culture, you will come back (#3).*

For these students, their willingness to interact with others arises from a strong commitment that more clearly embodies Kielhofner's (2002) dynamic interaction between their values, interests and sense of personal causation. Although these participants still have much to learn, their drive to become more culturally competent will increase the likelihood that they will attain this goal, and their excitement over the process will enhance that development.

There are important implications for occupational therapy educators as we consider the ideas above. If becoming culturally competent is a choice, the challenge

for educators is to determine how to motivate students to make that choice. For Whites, and we must remember that all of the participants in this study are Caucasian, choosing to engage in cross-cultural interactions may mean putting themselves into a vulnerable situation where they might make mistakes, are not in control, or may be rejected. For the dominant sociocultural group in the US, it is sometimes quite frightening to yield this much power. Why would anyone choose to do this? Educators might ask, what is the motivating factor? How can I facilitate students to want to choose to become culturally competent? And can I move them beyond the level of unreflective willingness? Can motivation and volition be fostered in an academic setting? An examination of Kielhofner's (2002) work on volition provides us with guidelines for an affirmative response. If volition is a dynamic interplay between values, interests, and personal causation, then an educator may attempt to develop teaching/learning strategies that will help students examine their own values about culture and diversity, spark their interest in learning more, and provide experiences that demonstrate that students can perform effectively in cross-cultural situations.

Although this is a challenging task (even daunting to some), there are numerous resources available from the disciplines of nursing, social work, and counseling psychology to support faculty who wish to develop better teaching/learning strategies for developing cultural competence. Only a few resources are available within the occupational therapy literature, however. A listing and discussion of these resources can be found in chapter two of this paper. I believe that these findings issue a challenge to the profession of occupational therapy to develop and/or support the development of teaching/learning guidelines and resources for the facilitation of cultural competence.

Self-Awareness

Another interesting finding from this study is the participants' failure to identify self-awareness as an important characteristic of cultural competence, compared to

many authors from the literature (Kavanagh & Kennedy, 1992; Pedersen, 1988; Pedersen& Ivey, 1993). Some of these authors even emphasized self-awareness as the most vital characteristic of the three which also includes cultural knowledge and skills (Chan, 1990; Harry, 1992; Lynch & Hanson, 1998; Weaver, 1999; Wells & Black, 2000). Surprisingly, only three of the study participants identified self-awareness as an attribute of cultural competence. I have to question why there is such a discrepancy between the reports in the literature, and the perceptions of these study participants. Was it the lack of cultural insight by the participants? Have they not had any training that emphasized the importance of cultural self-awareness as part of the development of cultural competence? Was it related to the maturity or development of the participants? Although the data don't provide the answers to these questions, an exploration of cognitive development theory and its relationship to the development of self awareness might be instructive.

I found very little information on the development of self-awareness as I reviewed the literature on cultural competence. Although Cross et al. (1989) identified a continuum of development of cultural competence, they did not address how an awareness of self occurs as part of the process. Leonard and Plotnikoff (2000) state that "becoming culturally aware is an awakening process in those committed to their own development and desire to serve others" (p. 53), but they do not delineate how that process occurs. McPhatter (1997) touches on the process when she discusses the development of "enlightened consciousness" which she states "requires a radical restructuring of a well-entrenched belief system that perceives oneself and one's culture, including values and ways of behavior" (p. 262). This process includes:

* a shifting of consciousness and awareness of just how narrow one's socialization has been
* critical review of one's beliefs and values
* acknowledgement of the shortcomings of one's education and socialization
* expression of the need to expand our knowledge and understanding of others

* a commitment to do the work necessary to move from the comfort of a monocultural existence to a multicultural existence (pp. 263 - 264).

An examination of the words of the study participants indicate that many are following the pattern that McPhatter suggests, but more needs to be understood about the process.

In a very recent article, Wittman and Velde (2002) briefly analyze and compare the ability to attain cultural competence with the development of critical thinking. Using the cultural continuum identified by Cross et al. (1989), (and described elsewhere in this paper) as their descriptor of the development of cultural competence, and comparing it with Perry's (1970) scheme of intellectual development, Wittman and Velde conclude that it is not possible for occupational therapy educators to develop the critical thinking skills necessary for the development of cultural competence. They base this argument on literature (King, Kitchener, & Wood, 1985; Welfel, 1982) that suggests that occupational therapy students will not perform beyond Perry's dualistic and multiplistic intellectual levels. Perry's theory is based on the way students understand and respond to authority and how they view the relationship of authority with knowledge acquisition. Wittman and Velde summarize Perry's levels in the following way. "The dualist sees authority figures as "all knowing" and looks to authority and the environment for the "right" answers. . . In the multiplicity stage, the individual sees knowledge as a matter of opinion" (p. 455). Their premise is that this is the way occupational therapy students think.

One argument against this theory is that occupational therapy educational programs are required to move to an entry level master's degree in 2007. Many of these programs will be post-baccalaureate programs catering to and attracting adult students. My own experience as the director of a program such is this has been with students that range in age from 23 to 55 who have numerous life experiences that have moved them to cognitive levels far beyond those identified by Wittman and Velde (2002). One can assume that many of these students are functioning at a higher cognitive level than Perry's (1970) dualistic and multiplistic stages, and do

have the critical thinking skills to move towards cultural competence.

Although Wittman and Velde's (2002) correlation of the development of cultural competence with the development of critical thinking is an interesting premise, I believe it is too simplistic. Cultural competence happens as a result not only of intellectual but also affective development. It is not clear how self-awareness fits into Perry's (1970) scheme.

It is not until I turn to feminist literature that I find a theory of development that combines both intellectual and affective components. Belenky, Clinchy, Goldberger and Tarule (1986) in their classic work *Women's ways of knowing: The development of self, voice, and mind,* identify a hierarchy that includes the development of self awareness as part of subjective knowing. An aspect of subjective knowledge is moving from a place where others' voices determine how you think and sometimes who you are, to a place where you begin to examine yourself as a viable knower and thinker. It is here that women "begin to assert their own authority and autonomy" (p. 77) and demonstrate an "increased experience of strength, optimism, and self-value" (p. 83). Debold, Tolman, and Brown (1996) describe this as "self-as-knower" which "describes an ongoing process in which "I" creates self from moment to moment within the context of internalized and situational power relations" (p. 92). They cite Mead (1934/1967) when he concluded that "there are all sorts of different selves answering to all sorts of different social reactions" (p. 142). According to these authors, the sense of self and self-awareness shifts as one experiences multiple social interactions which confirms one's recognition as self-as-knower. Recognizing that one is able to think for oneself is a heady feeling, leading to increased self-confidence.

I observed some of the behaviors identified above in the study participants who came from backgrounds with little diversity, where they may have heard or been taught racist or monocultural views as children. These women developed their own, more enlightened perspectives on culture and diversity when they moved away from home and into a more diverse environment. As a result of that shift, and the experiences that they have had within that more diverse environment, many

were able to voice their own ideas about culture and diversity, reflecting personal and subjective thinking and knowing, as opposed to presenting only ideas given to them by others (Belenky et al. 1986).

The theories above provide a beginning understanding of the development of self-awareness as a cognitive process, and touch upon how this development may impact one's ability to become culturally competent. Although the discussion above may provide some insight as to why only three of the study participants identified self-awareness as an important characteristic of cultural competence, more research is necessary to clearly identify the connection between self-awareness, cognition, critical thinking and cultural competence.

I believe these study findings also have important implications for occupational therapy education. It is clear from the literature on cultural competence that self-awareness is an important and vital attribute. Therefore, it is imperative for educators to help students develop their cultural self-awareness through learning exercises and strategies that help a student understand her standing and position within her sociocultural context, and how that sociocultural position impacts people from other contexts and cultures. For Caucasian students (and faculty), this will mean an examination of White privilege and the impact that may have on clinical practice. I have found that White students are often resistant to this work at first, but as they begin to become more aware of their privileged status in our society, their entire world view begins to change in a way that makes them more open to learning about others.

Although those who write about White privilege note that this is difficult work (Frankenberg, 1993; Howard, 1999; Kivel, 1996; McIntosh, 1988; Paley, 1996), I would argue that without this kind of work and this kind of education, without the development of one's cultural self-awareness, students will not attain the goal of cultural competence.

Learning Through Experience

Having cultural knowledge is one of the attributes of cultural competence identified both by the study participants and the literature. However, the students' concept of essential knowledge was quite limited in comparison to that found in the literature. Although the participants identified several items in a long list (chapter four) that they perceive are important to know, most of those items identified fell within the category of learning about others and their culture, and some fell within the category of self-knowledge. When discussing knowledge necessary for cultural competence, the literature recognizes the categories mentioned above by the students, but also considers a broader knowledge of societal roles, expectations, and issues of power and privilege (McPhatter, 1997). Perhaps the students in this study did not identify a broader range of relevant information because they have not had an opportunity to learn this information, and have not studied the concept of cultural competence in the way the authors have, either formally or informally, or had the opportunity to apply it in cross-cultural situations.

There are multiple methods through which students can gain knowledge about themselves and others, many of which are identified by both the study participants and the literature. But the most effective and perhaps transformative learning strategies identified by the study participants are those that actually involve cross-cultural experiences.

> *To actually be there and to have it be part of your experience and to see it and to feel it and to share it. All of a sudden it really hits home. It means something. It's real, not just a vague notion of what it would be. I think it opens your mind (#9).*

Experiential learning theory has proven over and over again the old adage, 'experience is the best teacher.' Drawing on the works of the Russian cognitive theorist, Vygotsky, and Dewey, Lewin, Piaget and other educational theorists, Kolb (1984) makes the case that "learning from experience is the process whereby human development occurs" (p. xi). Kolb later states that learning is "a process

whereby concepts are derived from and continuously modified by experience" (p. 26). I recognize the accuracy of that statement when I listen to the words of the study participants as they talk about how their understanding of people and a culture changes when they have an opportunity to actually interact with those particular people or that culture.

> *I read a lot and have people tell me about things. . . but until I go out and actually see it, it's abstract. But once you're doing it, and once you've done it, it becomes real. . . It's kind of like that "ah hah" moment. (#6).*

Within the cultural competence literature, several authors mention, but don't emphasize, that experience with people who are different from yourself is important in the development of cultural competence (Jones, Bond, & Mancini, 1998; Kiselica, 1991; Kramer & Bateman, 1999; Leonard & Plotnikoff, 2000; McPhatter, 1997; Pope-Davis, Prieto, Whitaker, & Pope-Davis, 1993; Sowers-Hoag & Sandau-Beckler, 1996). Pope-Davis, Breaux, and Liu (1997), however, are some of only a few authors who suggest that cross-cultural experiences might be fundamental, "because such in vivo experiences may provide the basis for reducing prejudice and racism" (p. 228). The authors cite the work of Stephan (1987) who reported that research indicates that "contact situations among members of different groups are expected to improve intergroup relations" (p.232), a concept known as the contact hypothesis. Contact among multiethnic groups have shown to improve relationships, especially if certain conditions such as equal status and an accepting social atmosphere are present (Rothbart & Lewis, 1994; Stephan, 1987). Pope-Davis et al. go on to say that contact between groups is more effective if significant time is spent together. Research studies suggest that short cross-cultural or simulated activities may actually increase students' ethnocentrism and biases (Bruschke, Gartner, & Seiter, 1993; Rothbart & Lewis, 1994). Bruschke et al. attribute this finding to a lack of adjustment time following a period of culture shock. Based on their examination of the literature, Pope-Davis et al. (1997) concluded that "the most valuable experiential exercise would be one of longer duration involving in vivo contact" (p. 232).

A cross-cultural immersion and exchange program described by Jones, Bond, and Mancini (1998) builds on the ideas expressed by Pope-Davis et al. (1997). In an effort to increase cultural competence in nurses in Dallas who work with an increasing number of Hispanic clients, a training model was developed that included a week of language and cultural learning experiences in Cuernavaca, Mexico for a group of Dallas nurses. The model also included an exchange program between nurses in Dallas and a hospital in Cuernavaca that would last between two and eight weeks. Upon evaluation of the project, Jones et al. found anecdotal evidence that suggested that participants greatly valued the experiences. but their major suggestion was to increase the length of the program. Jones et al. concluded that, although this model is a very positive step in the development of cultural competence, "the short duration of intense exposure may create a desire to learn more about the complexities within a specific culture, but it may also only highlight the need for additional intense, targeted experiences to continue the language and culture learning process" (1998, p. 287).

In an effort to evaluate the effectiveness of cross-cultural practice on cultural competence, Kim (1996) compared responses of occupational therapists who had only practiced in the United States to those who had practiced in another country for at least three weeks. Using the Multicultural Counseling Inventory (MCI) (Sodowsky, Taffe, & Gutkin, 1991) and adapting the questions to address occupational therapists rather than counselors, Kim examined the four areas of awareness, knowledge, skills, and relationship of 94 participants. Using statistical analysis, Kim found overall significant findings for the group of therapists who had practiced out of the country, indicating that international experiences increase the level of cultural competence. Interestingly, she also found that the length of stay in another country positively correlated to the level of awareness, supporting the findings and beliefs of Pope-Davis et al. (1997) and the other authors mentioned above. Kim's findings indicated that as the number of months of overseas practice increased, no matter which country the therapist practiced in, her self-awareness increased as well, as measured by the MCI.

Research in cultural competence and in experiential learning theory supports the importance of cross-cultural experience in the development of cultural competence, and also indicates the increased effectiveness of more lengthy experiences. Additionally, the current study participants identified their cross-cultural experiences as highly meaningful and transformational in nature.

> . . . *things change me when it directly happens to me. I mean, I can read about things and know more, but [the experience] really impacts me (#1)*

Not only do those experiences alter the participants' understanding, it shifts their own sense of self - who they are in a multicultural world. As Kolb (1984) might state, their own human development has progressed as a result of these cross-cultural interactions. There has been a transformation, not only in their knowledge, but in their very selves. Mezirow and his associates (2000) clearly explain this in the following.

> Transformative learning refers to the process by which we transform our taken-for-granted frames of reference (meaning perspectives, habits of mind, mind-sets) to make them more inclusive, discriminating, open, emotionally capable of change, and reflective so that they may generate beliefs and opinions that will prove more true or justified to guide action. . . Transformative learning has both individual and social dimensions and implications. It demands that we be aware of how we come to our knowledge and as aware as we can be about the values that lead us to our perspectives. (pp. 7-8).

Mezirow's words resound with the literature on the development of cultural competence, where people learn about their own values and cultural perspectives in order to have a greater understanding of people from diverse cultures. The participants in this study clearly articulated how personal encounters with culturally diverse people transformed their learning experiences

The voices of the students in this study must be heard. Their perspective is, that although they can learn from a variety of means, it is the *experiences* they have had with people who are culturally different than they are that have the greatest meaning for them. Cross-cultural experiences transform the knowledge they have gained in the classroom into a conceptual understanding that is bigger and better than

all the book knowledge they have gained. These experiences not only change what they know, it changes who they are.

Although the participants identified several other means of gaining knowledge, the experiences that they had with people who differed from themselves were the most meaningful for them. From this evidence, it became clear that cross-cultural experiences must be part of occupational therapy education if the goal is to facilitate the development of cultural competence for students.

The implications for occupational therapy educators are many. A determination must be made regarding the type and duration of these experiences and how these may be added to the curriculum. As stated above, the longer the experience, the more effective it is. This may mean changing curricula and course structure, increasing faculty development offerings and training, and finding additional funding for faculty who can provide supervision during these experiences.

Choosing the type of cross-cultural experience will differ with the educational facility. It might involve working with an HIV-hospice center across town, or teaching a group of immigrant women how to use public transportation or public facilities such as laundromats, or providing leisure activities in an inner city boys and girls club. It might also involve international study. Service learning projects are another effective way to engage students with community groups.

Cross-cultural experiences can require no additional cost to the educational program or they could be complex and costly. There are many approaches that can be used to reach this goal and each occupational therapy education program can determine which approach fits their mission and abilities. The importance of providing these experiences, however, is clearly heard in the voices of the participants of this study. I believe it is important to listen carefully and to learn from them.

Developing a Sense of Comfort

Another intriguing finding was the participants' interest in feeling comfortable in

cross-cultural interactions. Almost every participant spoke of it. Although they generally spoke of their own comfort, they also talked about the importance of comfort for the other person or client in a cross-cultural interaction. I was curious whether this was an attitude unique to this group of White students and went back to the literature to determine what had been written about this notion. I discovered that the Multicultural Counseling Inventory (MCI), an assessment tool designed by Sodowsky, Taffe, and Gutkin (1991), measures not only multicultural awareness, knowledge, and skills, but also a subsection called relationship. Within this area there are "eight items [which] measure the interaction process with the minority patient (e.g., comfort level, world view, and trustworthiness)" (Pope-Davis et al.. 1993, p. 840). I scoured the literature for research studies that used this tool as an assessment measure for cultural competence with the following limited results.

In the three research studies that were found using the MCI, the relationship sub scale was not mentioned in one (Pope-Davis & Ottavi, 1994), and was not found to significantly correlate to any other variables in the other two (Kim, 1999; Pope-Davis et al., 1993). There was nothing specific to "comfort level" discussed in any of the articles and none of these studies contributed to my understanding of this concept. The lack of information did make me wonder why that subsection was included in the assessment by Sodowsky et al. (1991).

However, other authors have included the issue of being comfortable in cross-cultural interactions. Kavenaugh and Kennedy (1992) address the importance of making the setting comfortable for the client in a list of goals they recommend "to facilitate communication among members of diverse groups" (p. 46). One study participant recognized this point as well.

> *. . . by allowing family members [to be] there [in the clinic during a treatment session], it [was] a more comfortable experience for the woman (#12)*

Betances (1999) talks about his use of humor to increase the comfort level while promoting multicultural understanding while other authors have a negative perspective of the importance of a sense of comfort in cross-cultural interactions.

DeMott (1999), in a provocative article entitled "Put on a happy face: Masking the difference between Blacks and Whites," comments on the need for White Americans to feel good about multiracial interactions. He talks about current films such as *Pulp Fiction, White Men Can't Jump, Die Hard With a Vengeance,* and the *Lethal Weapon* series which lull the American public into thinking that racism is no longer a problem. The biracial friendships portrayed in these movies between the White and Black characters is "the stuff of romance" (p. 359) and dreams, but this kind of portrayal does help to make people of the majority feel more comfortable with others. DeMott concludes with:

> The vision of friendship and sympathy placing blacks and whites "all in the same boat," rendering them equally able to do each other favors, . . . is a smiling but monstrous lie" (p. 365).

Although DeMott's words might be considered by some to be harsh, I wonder if this is what is going on with the participants in this study. Do they search for that sense of comfort in multicultural interactions because it makes them feel better and "takes them off the hook" of looking more closely at the realities of the lives of people from sociocultural non-dominant groups?

The participants spoke not only of their own comfort, but often of the importance of both parties feeling comfortable,

> *I think you need to feel comfortable with each other for it to be successful and competent (#6)*
>
> *The patient was happy and very comfortable (#12)*
>
> *[It was culturally competent] because the man was comfortable with it. (#1)*

I wonder if this is a concern mostly for Whites. Does a goal of being comfortable indicate a superficial level of interaction which does not permit the exploration of some of the "hard work" that is often necessary for good cross-cultural interactions? Is it a way for Whites to pacify themselves into thinking that everything is all right? Is this notion gender-related? Perhaps feeling comfortable in cross-cultural interactions is more of a trait of women. Gilligan (1993) and her colleagues have clearly identified the importance of maintaining relationships as a gender-related trait.

Perhaps male participants would respond in a different way.

Although I tend to think that the emphasis on being comfortable may be indicative of a more superficial or early stage of cultural competence, the data do not provide answers to these questions. Perhaps a better approach to developing cultural competence is to gently push people into a place of **dis**comfort in order to elicit more profound interactions with one another. I think this is one aspect of the data that deserves more research.

It is apparent from the data that being comfortable in cross-cultural interactions is important to the study participants and perhaps to students in general. What might be interesting is to explore with students what this sense of comfort means to them and how it contributes to their interaction patterns. This could be facilitated with self-awareness exercises, with journaling about their experiences, and with class or small group discussions about what makes them comfortable and uncomfortable in certain settings. It would be extremely interesting to include a group of ethnically and culturally diverse students to compare their reactions to those of the study participants who were all White women.

Although much of the data from this study correlated with the literature on cultural competence, the findings discussed above provide some unique information that has important implications for occupational therapy education and research. I believe that these findings may provide a basis for future examination of the phenomena of cultural competence and culturally competent care.

Summary of the Implications for Educators

I believe that the findings from this study have important implications for occupational therapy educators. First of all, educators must be cognizant of the characteristics of cultural competence, and knowledgeable about how these might be developed in students. They must also be aware of themselves as cultural beings, and know their own strengths and biases when working with those who are culturally different from themselves. This may mean additional faculty development

for many, which translates into a need for administrative support. This requires faculty to educate their administrators regarding the importance of this work.

Pedagogically, these study findings indicate that faculty need to provide learning experiences that develop cultural self-awareness in students, increase knowledge about the sociopolitical realities of our society, including issues of power, prejudice, and privilege, and provide opportunities to increase students' skill in cross-cultural experiences. These findings indicate that people choose to be culturally competent; that one must be motivated to do so; that one's volitional system must be engaged in the process. The challenge to faculty is to provide appropriate learning strategies that will increase interest and motivation in students, so that they are not only willing to engage in cross-cultural interactions, but also choose to do so.

Additionally, the participants in this study clearly articulated the need for cross-cultural experiences which transformed their learning. The mandate to educators and educational programs are clear. In order to increase knowledge and develop cross-cultural skills occupational therapy students must have the opportunity to interact with people who are culturally different from themselves. The literature indicates that the most effective learning happens with experiences that occur over a longer period of time, rather than a short-term encounter. This may mean semester-long experiences that could be as complex as international study, or it may mean working with local immigrants, or people with HIV within a community hospice setting. It might also mean working with another group of students in a program in another state who are culturally different from the students in your own program (Black & Bowen, 2002). The main goal of any of these activities would be to provide students with an opportunity to communicate with people who are culturally diverse in order to develop cross-cultural skills as part of the process of developing cultural competence.

Other challenges for occupational therapy educators include increasing their scholarship in the areas of culture, diversity, and cultural competence. The literature in these areas is extremely limited in our field. More research must be done that addresses the outcomes of pedagogical approaches mentioned above, and

research articles and theoretical and concept papers must be written to increase the knowledge about cultural competence in the field of occupational therapy.

There is a dearth of research in the United States on cultural competence. As educators begin to intentionally attempt to facilitate its development in the classroom and field, outcome studies that indicate the effectiveness of these efforts will be necessary. Findings from this study indicate the importance of cross-cultural experiences. Research that indicates which kinds of experiences are most beneficial would also add to the literature and knowledge. This study examined the perceptions of only White female students. An interesting extension of this study might include the perceptions of culturally diverse and male students as well.

Additional research on the relationship of volition to the development of cultural competence, and the meaning of the concept of comfort in cross-cultural interactions would build on the findings of this study as well. The American Occupational Therapy Association, in conjunction with the American Occupational Therapy Foundation has identified a research agenda wherein the impact of culture on a person's occupational (activity) choice and performance has been included as a priority. Any research which contributes to the knowledge and understanding of cultural competence will meet not only the needs of society but also the expressed needs and interests of the field.

Additionally, there is a desperate need for information and guidelines about how to teach for cultural competence. I challenge and encourage occupational therapy educators and practitioners who are addressing these areas in their work, to add to the developing body of literature on diversity and cultural competence. The benefit of such scholarship to educators, practitioners, students, the profession, and society in general is untold.

Limitations and Value of the Study

Perhaps the biggest limitation of this study was the researcher's unfamiliarity with the research methodology. In an effort to lessen this barrier, I did complete a

pilot study which I analyzed using Moustakas' (1994) method. I believed that this helped to familiarize me with the methodology, and I also believe that phenomenology is a viable research approach for occupational therapy research, but a person more skilled in this type of analysis might have drawn more from the data than I did.

Additionally, I made the mistake of not making copies of the interview tapes, and one transcriptionist I used early on became seriously ill and two tapes (one pilot and one research study) were lost. The results from the tape that was lost may have influenced the data analysis in some way. The loss of this tape was an important lesson to a novice researcher.

Typical of all types of qualitative research, the results from this study cannot be generalized, nor can the study be used as an outcomes study for occupational therapy education because it did not specifically correlate the findings with the students' educational experiences. However, the findings from this study certainly inform and have implications for the way educators teach for cultural competence.

The value of this study lies in the opportunity it provides to hear from students' voices how they perceive of and understand cultural competence and culturally competent care. Their voices are often missing from other studies in cultural competence. By listening carefully to what these students say, educators can know what and how they experience culturally competent care, what is important for them to know and learn, and what (in comparison with the literature findings) is missing in their education. The words of these students provide occupational therapy educators with a depth of understanding that is not found elsewhere. Their voices need to be heard, and their perceptions must inform the practice of occupational therapy education, particularly around the issues of diversity and cultural competence.

Closing

Since the events of 9/11/01, our world has changed in ways that are hard to imagine. Suspicion of Middle Easterners, Muslims, and other non-dominant groups

is at an all-time high. Because of the volatility of the world away from our shores, there has been an increase in the numbers of refugees and immigrants who come to the United States. Many of these people will seek out health care in settings that are mandated to provide competent care (Cross Cultural Health Care Center, 1995), but may find increased hostility because of world events. Their children will enter the US educational system needing support from related services such as occupational therapy in order to succeed. Because of these factors, and because of the general increase in diversity in the United States, more than ever before, there is a desperate need for culturally competent practice and care. Occupational therapy practitioners and other health care providers must be educated to effectively and competently provide the very best services to our nation's changing population. We must learn to work and play together with our culturally diverse neighbors, friends and colleagues. In order to do this well we must be culturally competent.

There is a great need to understand what being culturally competent means, particularly to the field of occupational therapy. We must recognize the attributes of cultural competence and culturally competent care so that educators might facilitate these in their students. This phenomenological research study begins to do that by examining how occupational therapy students perceive the essential features of cultural competence.

Although the theory of cultural competence is important, the practice of cultural competence is necessary. The findings from this study made me realize the necessity of providing cross cultural experiences for students. My future plans include finding ways for the occupational therapy students in my program to work with and provide services to the burgeoning Somali community in Lewiston, Maine. This experience will support the community as well as help occupational therapy students develop cross-cultural skills necessary for cultural competence. In conjunction with this plan, I would like to research the effects of these interactions on both the students and the community members, and report the results to the larger occupational therapy community through a published article. It is my hope that many other studies will follow, and I encourage my colleagues to join me in this effort.

REFERENCES

Abney, V.D. (1996). Cultural competency in the field of child maltreatment. In J. Briere & L. Berliner (Eds.). *The APSAC handbook on child maltreatment.* Thousand Oaks, CA: Sage Publications, Inc. 409- 419.

Abrums, M. E. & Leppa, C. (2001). Beyond cultural competence: Teaching about race, gender, class, and sexual orientation. *Journal of Nursing Education, 40* (6), 270-275.

Allison, K. W., Echemendia, R.J., Crawford, I., & LaVome Robinson. (1996). Predicting cultural competence: Implications for practice and training. *Professional Psychology: Research and Practice, 27* (4), 386-393.

Alpers, R.R. & Zoucha, R. (1996). Comparison of cultural competence and cultural confidence of senior nursing students in a private southern university. *Journal of Cultural Diversity, 3* (1), 9-15.

American Occupational Therapy Association. (1991). *Essentials and guidelines for an accredited occupational therapy educational program.* Bethesda, MD: Author.

American Occupational Therapy Association (1998). *Standards for an accredited educational program for the occupational therapist.* Accreditation Council for Occupational Therapy Education (ACOTE). Author.

American Occupational Therapy Association (2000). Position statement on occupational therapy's commitment to nondiscrimination and Inclusion. *Reference guide to the occupational therapy code of ethics.* Bethesda, MD:

Author.

Andrews, M.M. (1992). Cultural perspectives on nursing in the 21st century. *Journal of Professional Nursing, 8* (1), 7-15.

AOTA Multicultural Task Force. (1995). *Definition and terms.* Bethesda, MD: American Occupational Therapy Association.

Austin,W., Gallop, R., McCay, E., Peternelj-Taylor, C. & Bayer, M. (1999). Culturally competent care for psychiatric clients who have a history of sexual abuse. *Clinical Nursing Research, 8*(1), 5-25.

Babyar, S.R., Sliwinski, M., Krasilovsky, G. , et al. (1996). Survey of inclusion of cultural and gender issues in entry-level physical therapy curricula in New York state. *Journal of Physical Therapy Education, 10* (2), 53-62.

Bailey, D.M. (1997). *Research for the health professional: A practical guide, 2nd ed.* Philadelphia: F.A.Davis.

Bailey, D. M. (2000). Introducing an awareness of cultural diversity into an established curriculum. *Innovations in Occupational Therapy Education.* P. Crist (Ed.). Bethesda, MD: American Occupational Therapy Association. 134-145.

Barney, K. (1989a). Cultural awareness perspectives - Introduction. *Gerontology Special Interest Section Newsletter, 12* , 1-2. Rockville, MD: American Occupational Therapy Association.

Barney, K. (1989b). Cultural sensitivity issues, part II - introduction. *Gerontology Special Interest Section Newsletter, 12*, 1. Rockville, MD: American

Occupational Therapy Association.

Barney, K. F. (1991). From Ellis Island to assisted living: Meeting the needs of older adults from diverse cultures. *The American Journal of Occupational Therapy, 45* (7), 586- 593.

Belenky, M.F., Clinchy, B.M., Goldberger, N. R., & Tarule, J.M. (1986). *Women's ways of knowing: The development of self, voice, and mind.* New York: Basic Books, Inc., Publishers.

Bennett, C.I. (1995). *Comprehensive multicultural education: Theory and practice, 3rd ed.* Boston: Allyn and Bacon.

Bernal, H., & Froman, R. (1993). Influences on the cultural self-efficacy of community health nurses. *Journal of Transcultural Nursing, 4*(2), 24-31.

Betances, S. (1999). Using humor to promote multicultural understanding. In. J. Q. Adams & J. R. Welsch (Eds.), *Cultural diversity: Curriculum, classroom, & climate* (pp. 219-224). Illinois: Illinois Staff and Curriculum Developers Association.

Beverly, A. (1992). Transforming the nursing curriculum: Integrating concepts of gender, race, class, and ethnicity. *Dean's Notes: A communications service to nursing school deans, administrators, and faculty, 13* (4), 1-3.

Black, R.M. (2002). Occupational therapy's dance with diversity. *American Journal of Occupational Therapy, 56* (2), 140-148.

Black, R.M. & Bowen, J. (2002). Cross-cultural partnerships. A presentation at the Mountain Central Conference, San Antonio, Texas. September 27.

Boles, E. (1971). *Changing social patterns.* Committee on Basic Professional Education. Education Forum X. American Occupational Therapy Association, New York, N.Y.

Bonder, B., Martin, L., & Miracle, A. (2002) *Culture in clinical care.* Thorofare, NJ: SLACK Inc.

Boyle, (1999). The road less traveled. *International Social Work, 42*(2), 208-209.

Bruschke, J.C., Gartner, C., & Seiter, J.S. (1993). Student ethnocentrism, dogmatism, and motivation: A study of BAFA BAFA. *Simulation and Gaming, 24*, 9-20.

Campinha-Bacote, J. (1998). Cultural diversity in nursing education: Issues and concerns. *Journal of Nursing Education,m 37*(1), 3-4.

Canadian Association of Occupational Therapists. (1991). *Occupational therapy guidelines for client-centered practice.* Toronto, ON: CAOT Publications ACE.

Carpio, B.A., & Majumdar, B. (1991). Putting culture into curricula. *The Canadian Nurse, 87*(7), 32-33.

Cauce, A.M., Coronado, N., & Watson, J. (1998). Conceptual, methodological, and statistical issues in culturally competent research. In M. Hernandez & M.R. Isaacs, (Eds.). *Promoting cultural competence in children's mental health services.* Baltimore: Paul. H. Brookes Publishing Co. 305-329.

Chan, S.Q. (1990). Early intervention with culturally diverse families of infants and

toddlers with disabilities. *Infants and Young Children, 3*(2), 78-87.

Chin, J.L. (2000). Culturally competent health care. *Public Health Reports 115,* January/February, 25-33.

Christiansen, C. & Baum, C. (Eds.) (1997). *Occupational therapy: Enabling function and well-being. 2nd. ed.* Thorofare, N.J.: SLACK, Inc.

Coffey, A. & Atkinson, P. (1996). *Making sense of qualitative data.* Thousand Oaks, CA: SAGE Publications.

Cohen, M.Z., Kahn, D.L., & Steeves, R.H. (2000). *Hermeneutic phenomenological research: A practical guide for nurse researchers.* Thousand Oaks, CA: Sage Publications.

Committee on Basic Professional Education, Educational Forum VIII. (1969). *Educational aspects of the changing role of the occupational therapist (Community practice).* American Occupational Therapy Association. New York, N.Y.

Creswell, J.W. (1994). *Research design: Qualitative and quantitative approaches.* Thousand Oaks, CA: SAGE publications.

Creswell, J.W. (1998). *Qualitative inquiry and research design: Choosing among* five *traditions.* Thousand Oaks, CA: SAGE publications.

Cross,T., Bazron, B., Dennis, K., & Isaacs, M. (1989). *Towards a culturally competent system of care, Volume 1.* Washington, D.C.: Georgetown University Child Development Center, CASSP Technical Assistance Center.

Cross Cultural Health Care Center (1995). *Measuring cultural competence in health care: Recommendations for national standards and an outcomes-focused research agenda.* Silver Spring, MD.

Cui, G., & Awa, J.E. (1992). Measuring intercultural effectiveness: An integrating approach. *International Journal of Intercultural Relations, 16,* 311-328.

Cultural competence practice and training: Overview. Retrieved on February 22, 2000, from http://www.diversityrx.org/HTML/MOCPT1/htm.

Curry, L., Wergin, J.F., & Associates. (1993). *Educating professionals: Responding to new expectations for competence and accountability.* San Francisco: Jossey-Bass Publishers.

D'Andrea, M., Daniels, J. & Heck, R. (1991). Evaluating the impact of multicultural counseling training. *Journal of Counseling & Development, 70,* 143-150.

Darling, C.A., Greenwood, B.B., & Hansen-Gandy, S. (1998). Multicultural education in collegiate family and consumer sciences programs: Developing cultural competence. *Journal of Family and Consumer Sciences*, Spring. 42-48.

Davidhizar, R., Bechtel, G., & Giger, J.N. (1998). A model to enhance culturally competent care. [Electronic version]. *Hospital Topics, 76* (2), 1-10.

Davidhizar, R. & Giger, J. N. (2001). Teaching culture within the nursing curriculum using the Giger-Davidhizar Model of Transcultural Nursing Assessment. *Journal of Nursing Education, 40* (6), 282-284.

Debold, E., Tolman, D., & Brown, L.M. (1996). Embodying knowledge, knowing desire: Authority and split subjectivities in girls' epistemological development. In N. Goldberger, J. Tarule, B. Clinchy, & M. Belenky (Eds.). *Knowledge, difference, and power: Essays inspired by Women's Ways of Knowing.* (pp. 85-125). New York: BasicBooks.

Delpit, L. (1995). *Other people's children.* New York: The New Press.

DeMars, P.A. (1992). An occupational therapy life skills curriculum model for a Native American tribe: A health promotion program based on ethnographic field research. *American Journal of Occupational Therapy, 46* (8), 745-750.

DeMott, B.(1999). Put on a happy face: Masking the differences between Blacks and Whites. In C.A. Gallagher (Ed.), *Rethinking the color line* (pp. 358-365). Mountain View, CA: Mayfield Publishing Company.

Dillard, M., Andonian, L., Flores, O., Lai, I., MacRae, A., & Shakir, J., (1992). Culturally competent occupational therapy in a diversely populated mental health setting. *American Journal of Occupational Therapy,46* (8), 721-726.

Dinges, N.G. & Baldwin, K.D. (1996). Intercultural competence: A research perspective. In D. Landis & R.S.Bhagat (Eds.). *Handbook of intercultural training, 2nd Ed.* Thousand Oaks, CA: SAGE Publications, 106-123.

Dowd, S.B., Giger, J.N., & Davidhizar, R. (1998). Use of Giger and Davidhizar's transcultural assessment model by health professions. *International Nursing Review, 45* (4), 119-128.

Dunn, W., Brown, C., & McGuigan, A. (1994). The ecology of human performance: A framework for considering the effect of context. *American Journal of*

Occupational Therapy, 48, 595-607.

Dyck, I. (1991). Multiculturalism and occupational therapy: Sharing the challenge. National Perspective. *Canadian Journal of Occupational Therapy, 58*(5), 224-226.

Fadima, A. (1997). *The spirit catches you and you fall down.* New York: Farrar, Straus and Giroux.

Finlay, L. (1999). Applying phenomenology in research: Problems, principles and practice. *British Journal of Occupational Therapy, 62*(7). 299-306.

Fong, L.G.W., & Gibbs, J. T. (1995). Facilitating services to multicultural communities in a dominant culture setting: An organizational perspective. *Administration in Social Work, 19* (2), 1-24.

Forwell, S. (2000). Exploring how rehabilitation students acquire cultural competency: Methodology and ethical considerations. In Hammell, Carpenter, & Dyck (Eds.). *Using Qualitative Research: A practical introduction for occupational and physical therapists. (*pp.73-83). Edinburgh, Scotland: Churchill Livingstone.

Forwell, S.J., Whiteford, G., & Dyck, I. (2001). Cultural competence in New Zealand and Canada: Occupational therapy students' reflections on class and fieldwork curriculum. *Canadian Journal of Occupational Therapy, 68*(2). 90 - 103.

Frankenberg, R. (1993). *White women, race matters:The social construction of whiteness.* Minneapolis, MN: University of Minnesota Press.

Geertz, C. (1973). *The interpretation of culture.* New York: Basic Books.

Gerrish, K. & Papadopoulos, I. (1999). Transcultural competence: The challenge for nurse education. *British Journal of Nursing, 8*(21), 1453-1457.

Giger, J. N. (2000). Developing culturally competent care techniques to assist African-Americans to survive in the 21st century. *Journal of National Black Nurses Association, 11* (1), vii -viii.

Giger, J., & Davidhizar, R. (1999). *Transcultural nursing: Assessment and intervention.* St. Louis: Mosby Year Book.

Gilligan, C. (1993). *In a different voice: Psychological theory and women's development.* Cambridge, MA: Harvard University Press.

Gim, R.H., Atkinson, D.R., & Kim, S.J. (1991). Asian-American acculturation, counselor ethnicity and cultural sensitivity, and ratings of counselors. *Journal of Counseling Psychology, 38* (1), 57-62.

Glesne, C. & Peshkin, A. (1992). *Becoming qualitative researchers: An introduction.* White Plains, NY: Longman.

Gonser, P.A. (2000). Culturally competent care for members of sexual minorities. *Journal of Cultural Diversity, 7* (3), 72-75.

Hager, P., & Gonczi, A. (1996). What is competence? *Medical Teacher 18* (1), 15-18.

Hagey, R. (1988). Retrospective on the culture concept. *Recent Advances in Nursing, 20,* 1-10.

Harris, S.H., & Cummings, S.H. (1996). Reflections on ethnocentrism and racism: A challenge for advanced practice nurses. *Advanced Practice Nursing Quarterly, 2*(2), 70-74.

Harry, B. (1992). Developing cultural self-awareness: The first step in values clarification for early interventionists. *Topics in Early Childhood Special Education, 12,* 333-350.

Helms, J.E. (1993). I also said, "White racial identity influences White researchers." *Counseling Psychologist, 21,* 240-243.

Helms, J.E. (1994). How multiculturalism obscures racial factors in the therapy process: Comment on Ridley et al. (1994), Sodowsky et al, (1994), Ottavi et al. (1994), and Thompson et al., (1994). *Journal of Counseling Psychology, 41,* 162-165.

Herbst, P.H. (1997). *The color of words: An encyclopedic dictionary of ethnic bias in the United States.* Yarmouth, ME: Intercultural Press.

Hernandez, M. & Isaacs, M.R. (1998). *Promoting cultural competence in children's mental health services.* Baltimore, MD: Paul H. Brookes Publishing Co.

Horger, M.M. & McGruder, J.E. (1995). *Establishing multicultural competence: Comparison of two educational models.* Paper presented at the American Occupational Therapy Association's Annual Conference, Denver, Colorado.

Howard, G.R. (1999). *We can't teach what we don't know: White teachers, multiracial schools.* New York: Teachers College Press.

Johnson, S.D. (1982). *The Minnesota multiethnic counselor education curriculum: The design and evaluation of an intervention for cross-cultural counselor education.* Unpublished doctoral dissertation. University of Minnesota, Minneapolis.

Johnson, S.D. (1987). Knowing that versus knowing how: Toward achieving expertise through multicultural training for counsel. *The Counseling Psychologist, 15,* 320-331.

Jones, M. E., Bond, M.L., & Mancini, M. E. (1998). Developing a culturally competent work force: An opportunity for collaboration. *Journal of Professional Nursing, 14* (5), 280-287.

Kadushin, G., & Egan, M. (1997). Educating students for a changing health care environment: An examination of health care practice course content. *Health & Social Work, 22* (3), 211-222.

Kavanagh, K.H., & Kennedy, P.H. (1992). *Promoting cultural diversity: Strategies for health care professionals.* Newbury Park, CA: Sage.

Khamisha, C. (1997). Cultural diversity in Glasgow, part 1: Are we meeting the challenge? *British Journal of Occupational Therapy, 60* (1), 17-22.

Kielhofner, G. (1997). *Conceptual foundations of occupational therapy. 2nd ed.* Philadelphia: F. A. Davis.

Kielhofner, G. (2002). *A model of human occupation: Theory and application. 3rd. ed.* Baltimore, MD: Lippincott Williams & Wilkins.

Kim, B.M. (1996). The impact of cross-cultural practice on multicultural competence

among occupational therapists. Unpublished master's thesis. Rush University, Chicago, IL.

Kinebanian, A. & Stomph, M. (1992). Cross-cultural occupational therapy: A critical reflection. *American Journal of Occupational Therapy, 46*(8), 751-757.

King, P.M., Kitchener, K.S., & Wood, P.K. (1985). The development of intellect and character: A longitudinal-sequential study of intellectual and moral development in young adults. *Moral Education Forum, 10*(1), 1-13.

Kiselica, M.S. (1991). Reflections on a multicultural internship experience. *Journal of Counseling & Development, 70,* 126-130.

Kivel, P. (1996). *Uprooting racism: How white people can work for racial justice.* Philadelphia, PA: New Society Publishers.

Koester, J., & Olebe, M. (1988). The behavioral assessment scale for intercultural communication effectiveness. *International Journal of Intercultural Relations, 12,* 233-246.

Kolb, D.A. (1984). *Experiential learning: Experience as the source of learning and development.* Englewood Cliffs, NJ: Prentice Hall P T R.

Kramer, E.J. & Bateman, W.B. (1999). A cultural competence curriculum. In Kramer, E.J., Ivery, S.L., & Ying. (Eds.). *Immigrant women's health: Problems and solutions.* (pp. 322-329). San Francisco: Jossey-Bass Publishers.

Kyler, P. (Ed.).(2002). *Reference guide to the occupational therapy code of ethics.* Bethesda, MD: The American Occupational Therapy Association, Inc.

LaBelle T.J. & Ward, C.R. (1994). *Multiculturalism and education: Diversity and its impact on schools and society.* Albany, NY: State University of New York Press.

Law, M. (Ed.). (1998). *Client-centered occupational therapy.* Thorofare, N.J.: SLACK, Inc.

Law, M., Cooper, B., Strong, S., Stewart, D., Rigby, P., & Letts, L., (1996). The person-environment-occupation model: A transactive approach to occupational performance. *Canadian Journal of Occupational Therapy, 63*, 9-23.

Lea, A. (1994). Nursing in today's multicultural society: A transcultural perspective. *Journal of Advanced Nursing, 20,* 307-313.

Lee, M., & Greene, G.J. (1999). A social constructivist framework for integrating cross- cultural issues in teaching clinical social work. *Journal of Social Work Education, 35*(1), 21-39.

Leininger, M. (1978). *Transcultural nursing: Concepts, theories, and practices.* New York: Wiley.

Leininger, M. (1994). Culturally competent care: Visible and invisible. *Journal of Transcultural Nursing, 6*(1), 23-25.

Lenburg, C.B. (Ed.). (1995). *Promoting cultural competence in and through nursing education.* Washington, D.C.: American Academy of Nursing.

Leonard, B.J. & Plotnikoff, G.A. (2000). Awareness: The heart of cultural competence. *AACN Clinical Issues, 11*(1), 51-59.

Leong, F.T.L., & Kim, H.H.W. (1991). Going beyond cultural sensitivity on the road to multiculturalism: Using the intercultural sensitizer as a counselor training tool., *Journal of Counseling & Development, 70,* 112 - 118.

Lum,D. (1986). *Social work practice and people of color.* Monterey, CA: Brooks-Cole.

Lynam, M.J. (1992). Towards the goal of providing culturally sensitive care: Principles upon which to build nursing curricula. *Journal of Advanced Nursing, 17,* 149-157.

Lynch, E.W., & Hanson, M.J. (1998). *Developing cross-cultural competencies: A guide for working with children and their families, 2nd ed.* Paul H. Brooks Publishing Co. (chap. 3). Retrieved February 2, 2000, from http://www.pbrookes.com/e-catalog/books/lynch-3319/excerpt.htm.

MacDonald, J.(1998). What is cultural competency? *British Journal of Occupational Therapy, 61,* 325-328.

MacDonald, J. & Rowe, N. (1995). Minority ethnic groups and occupational therapy, part 2: Transcultural occupational therapy, a curriculum for today's therapist. *British Journal of Occupational Therapy, 58*(7), 286-290.

MacPhee, D., Kreutzer, J.C., & Fritz, J.J. (1994). Infusing a diversity perspective into human development courses. *Child Development, 65,* 699-715.

Mahoney, J. S. & Engebretson, J. (2000). The interface of anthropology and nursing guiding culturally competent care in psychiatric nursing. *Archives of Psychiatric Nursing, 14*(4), 183-190.

Manoleas, P. (1994). An outcome approach to assessing the cultural competence of MSW students. In P.R. Keys (Ed). *School social workers in the multicultural environment: New roles, responsibilities, and educational enrichment.* New York: The Haworth Press, Inc., 43-57.

Martin, J.N. (1987). The relationship between student sojourner perceptions of intercultural competencies and previous sojourn experiences. *International Journal of Intercultural Relations 11*, 337-355.

Martin, R.M. (1986). A study of Black preschool children's performance on the Miller Assessment for Preschoolers. Richmond, VA: Chesterfield County School System.

Maxwell, J.A. (1996). *Qualitative research design: An interactive approach.* Thousand Oaks, CA: SAGE Publications.

McCormack, G.L. (1987). Culture and communication in the treatment planning for occupational therapy with minority patients. *Occupational Therapy in Health Care, 4*(1), 17-36,

McCree, S. (1989). Sensitivity to the Black elderly client. *Gerontology special Interest Section Newsletter, 12*, 1-2. Rockville, MD: American Occupational Therapy Association.

McGee, P. (1992). *Teaching transcultural care: A guide for teachers of nursing and health care.* London: Chapman & Hall.

McGee, P. (1994). Educational issues in transcultural nursing. *British Journal of Nursing, 3*(21), 1113-1116.

McIntosh, P. (1988). *White privilege and male privilege: A personal account of coming to see correspondences through work in women's studies.* (Working Paper No. 189). Wellesley, MA: Wellesley College Center for Research on Women.

McNicoll, P. (1999). Issues in teaching participatory action research. *Journal of Social Work Education, 35* (1), 51-68.

McPhatter, A.R. (1997). Cultural competence in child welfare: What is it? How do we achieve it? What happens without it? *Child Welfare, 76* (1), 255-278).

McRae, M.B. & Johnson, S.D. (1991). Toward training for competence in multicultural counselor education. *Journal of Counseling & Development, 70,* 131-135.

Mead, G.H. (1934/1967). *Mind, self, and society.* Chicago: University of Chicago Press.

Meleis, A.I. (1996). Culturally competent scholarship: Substance and rigor. *Advanced Nursing Science, 19* (2), 1-16.

Merriam-Webster. (1995). *Merriam-Webster Dictionary.* Springfield, MA: Merriam-Webster, Inc.

Merrill, S.C. (Ed.). (1992). *Occupational therapy across cultural boundaries: Theory, practice, and professional development.* New York: The Haworth Press.

Mezirow, J. (1991). *Transformative dimensions of adult learning.* San Francisco: Jossey-Bass.

Mezirow, J., and Associates (2000). *Learning as transformation: Critical*

perspectives on a theory in progress. San Francisco: Jossey-Bass.

Midgette, T.E. & Meggert, S.S. (1991). Multicultural counseling instruction: A challenge for the faculties in the 21st century. *Journal of Counseling & Development, 70,* 136-141.

Miles, M. B. & Huberman, A. M. (1994). *Qualitative data analysis, 2nd Ed.* Thousand Oaks, CA: SAGE Publications.

Monahan,B. (1997). The quest for diversity in the classroom. *PT Magazine, January.* 72-77.

Moustakas, C. (1994). *Phenomenological research methods.* Thousand Oaks, CA: SAGE Publications.

Myers, C. (1992). Hmong children and their families: Consideration of cultural influences in assessment. *American Journal of Occupational Therapy, 46* (8), 727-736.

Nakanishi, M. & Rittner, B. (1992). The inclusionary cultural model. *Journal of Social Work Education, 28* (1), 27-35.

Napholz, L. (1999). A comparison of self-reported cultural competency skills among two groups of nursing students: Implications for nursing education. *Journal of Nursing Education, 38* (2), 81-83.

Nwachuku, U.T., & Ivey, A. E. (1991). Culture-specific counseling: An alternative training model. *Journal of Counseling & Development, 70,* 106-111.

Olebe, M., & Koester, J. (1989). Exploring the cross-cultural equivalence of the

Behavior Assessment Scale for Intercultural Communication. *International Journal of Intercultural Relations, 17,* 355-379.

Paley, V.G. (1996). *White teacher.* Cambridge, MA: Harvard University Press.

Patton, M.Q. (1990). *Qualitative evaluation and research methods. 2nd ed.* Newbury Park, CA: SAGE Publications.

Paulson, C.P. (1975). *Delinquency and occupational choice.* Los Angeles: University of Southern California.

Pedersen, P. B. (1977). Four dimensions of cross-cultural skill in counselor training. *The Personnel and Guidance Journal, 56* (10), 480-484.

Pedersen, P. B. (1988). *A handbook for developing multicultural awareness.* Alexandria, VA: American Association for Counseling and Development.

Pedersen, P.B. & Ivey, A.(1993). *Culture-centered counseling and interviewing skills.* Westport, CT: Praeger.

Perry, W.G. (1970). *Forms of intellectual and ethical development in the college years: A scheme.* New York: Holt, Rinehart, & Winston.

Pinto, J.D.M. (1978). The involvement of occupational therapy with minority groups. *World Federation of Occupational Therapists: Bulletin 2* (12-14).

Ponterotto, J. G. (1997). Multicultural counseling training. In D.B. Pope-Davis & H.L.K. Coleman (Eds.). *Multicultural counseling competencies: Assessment, education and training, and supervision.* Thousand Oaks, CA: SAGE Publications. 111-130.

Ponterotto, J.G., Rieger, B.P., Barrett, A., & Sparkes, R. (1994). Assessing multicultural counseling competence: A review of instrumentation. *Journal of Counseling & Development, 72,* 316-322.

Pope-Davis, D.B., Breaux, C., & Liu, W.M. (1997). A multicultural immersion experience: Filling a void in multicultural training. In D.B. Pope-Davis & H.L.K. Coleman (Eds.) *Multicultural counseling competencies: Assessment, education and training and supervision,* pp 227-241. Thousand Oaks, CA: SAGE Publications.

Pope-Davis, D.B. & Coleman, H.L.K. (Eds.). (1997). *Multicultural counseling competencies: Assessment, education and training, and supervision.* Thousand Oaks, CA: SAGE Publications.

Pope-Davis, D.B. & Dings, J. G. (1994). An empirical comparison of two self-report multicultural counseling competency inventories. *Measurement and Evaluation in Counseling and Development, 27* (2), 93-102.

Pope-Davis, D.B., Eliason, M.J., & Ottavi, T.M. (1994). Are nursing students multiculturally competent? An exploratory investigation. *Journal of Nursing Education, 33* (1), 31-33.

Pope-Davis, D.B. & Ottavi, T.M. (1994). Examining the association between self-reported multicultural counseling competencies and demographic variables among counselors. *Journal of Counseling & Development, 72,* 651-654.

Pope-Davis, D., Prieto, L.R., Whitaker, C.M., & Pope-Davis, S. (1993). Exploring multicultural competencies of occupational therapists: Implications for education and training. *American Journal of Occupational Therapy, 47* (9),

838-844.

Purnell, L. (1999). Culturally competent care for traditional Appalachians. *NASA/IMPRINT,* November/December, 56-59.

Ramsey, M. (1994). Use of a Personal Cultural Perspective Profile (PCPP) in developing counselor multicultural competence. *International Journal for the Advancement of Counseling, 17* (4), 283-290.

Raphael, E.I. (1988). Grandparents: A study of their role in Hispanic families. *Physical and Occupational Therapy in Geriatrics, 6*, 31-62.

Reynolds, A. L. (1997). Using the multicultural change intervention matrix (MCIM) as a multicultural counseling training model. In D.B. Pope-Davis & H.L.K. Coleman, *Multicultural counseling competencies: Assessment, education and training, and supervision.* Thousand Oaks, CA: SAGE Publications. 209-226.

Rogers, M. R. (1998). The influence of race and consultant verbal behavior on perceptions of consultant competence and multicultural sensitivity. *School Psychology Quarterly, 13*(4), 265-280.

Ronnau, J.P. (1994). Teaching cultural competence: practical ideas for social work educators. In P.R.Keys (Ed.). *School social workers in the multicultural environment: New roles, responsibilities, and educational enrichment.* New York: The Haworth Press, Inc., 29-42.

Rothbart, M., & Lewis, S. (1994). Cognitive processes and intergroup relations: A historical perspective. In P. G. Devine, D. L. Hamilton, & T.M. Ostrom (Eds.), *Social cognition: Impact on social psychology,* pp. 175 - 183. San

Diego, CA: Academic Press.

Sanchez, V. (1964). Relevance of cultural values for occupational therapy programs. *American Journal of Occupational Therapy, 18*(1), 1-5.

Sayles-Folks, S. & People, L. (1990). Cultural sensitivity training for occupational therapists. *Physical Dysfunction Newsletter, 13*(3), 4-5.

Schilder, A.J., Kennedy, C., Goldstone, I.L., Ogden, R.D., Hogg, R.S., and O'Shaughnessy, M.V. (2001). "Being dealt with as a whole person." Care seeing and adherence: the benefits of culturally competent care. *Social Science & Medicine, 52,* 1643-1659.

Schkade, J.K. & Schultz, S. (1992). Occupational adaptation: Toward a holistic approach for contemporary practice, Part 1. *American Journal of Occupational Therapy, 46,* 829-837.

Schon, D. (1995). *The reflective practitioner: How professionals think in action.* Aldershot, England: Ashgate Publishing Limited.

Scott, R. (April 1997). Investigation of cross-cultural practice: Implications for curriculum development. *Canadian Journal of Occupational Therapy.* 89-96.

Seidman, I.E. (1991). *Interviewing as qualitative research.* New York: Teachers College Press.

Sims, G. P., & Baldwin, D. (1995). Race, class, and gender considerations in nursing education. *N & HC: Perspectives on Community, 16* (6), 316-321.

Singleton, S.M. (1994). Faculty personal comfort and the teaching of content on racial

oppression. In P.R. Keys (Ed.). *School social workers in the multicultural environment: New roles, responsibilities, and educational enrichment.* New York: The Haworth Press, Inc., 5-16.

Smart, J. F., & Smart, D.W. (April/May/June 1992). Cultural issues in the rehabilitation of Hispanics. *Journal of Rehabilitation.* 29-37.

Smith, L.S. (1998). Concept analysis: Cultural Competence. *Journal of Cultural Diversity, 5* (1), 4 - 9.

Sodowsky, G.R., Taffe, R.C., Gutkin, T.B., & Wise, S.L. (1994). Multicultural counseling inventory (MCI): A self-report measure of multicultural counseling competencies. *Journal of Counseling Psychology.*

Sookhoo, D., Adams, J., & Anionwu, E. (2000). In the melting pot. *Nursing Times, 96* (29), 40-41.

Sowers-Hoag, K.M. & Sandau-Beckler, P. (1996). Educating for cultural competence in the generalistcurriculum. *Journal of Multicultural Social Work, 4*(3), 37-56.

Spector, R.E. (1996). *Cultural diversity in health & illness. 4th ed.* Stamford, CT: Appleton & Lange.

St. Clair, A. & McKenry, L. (1999). Preparing culturally competent practitioners. *Journal of Nursing Education, 38* (5), 228-234.

Stanfield II, J.H. (1993). Methodological reflections. In J.H. Stanfield II & Rutledge M. Dennis (Eds.), *Race and ethnicity in research methods* (3 - 15). Newbury Park, CA: SAGE.

Stephan, W.G. (1987). The contact hypothesis in intergroup relations. in C. Hendrick (Ed.), *Group processes and intergroup relations.* Newbury Park, CA: Sage.

Strauss,A. (1987). *Qualitative analysis for social scientists.* New York: Cambridge University Press.

Sue, D.W. (1981). *Counseling the culturally different: Theory and practice.* New York: John Wiley & Sons.

Sue, D.W. (1996). Multicultural counseling: Models, methods and actions. *The Counseling Psychologist, 24*(2), 279-284.

Sue, D. W. (1997). Multicultural training. *International Journal of Intercultural Relations, 21*(2), 175-193.

Sue, D.W. (1998). *Multicultural counseling competencies: Individual and organizational development.* Thousand Oaks, CA: SAGE publications.

Sue, D.W., Arredondo, P., and McDavis, R.J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling & Development, 70* (2), 477-486.

Sue, D. W. & Sundberg, N.D. (1996). Research and research hypotheses about effectiveness in intercultural counseling. In P.B. Pedersen, J.G. Draguns, W.J. Lonner, & J. E. Trimble (Eds.) *Counseling across cultures, 4th Ed.* Thousand Oaks, CA: SAGE Publications.

Sue, S. (1998). In search of cultural competence in psychotherapy and counseling. *American Psychologist 53*(4), 440-448.

Trolander, J.A. (1997). Fighting racism and sexism: The council on social work education. *Social Service Review, 71* (1), 110-134.

Tuck, I., & Harris, L.H. (1988). Teaching students transcultural concepts. *Nurse Educator, 13* (3), 36-39.

Uehara, E.S., Sohng, S.S.L., Bending, R.L., Seyfried, S., Richey, C.A., Morelli, P., Spencer, M., Ortega, D., Keenan, L., & Kanuha, V. (1996). Toward a values-based approach to multicultural social work research. *Social Work, 41*(6), 13-27.

U.S. Department of Health and Human Services. (1994). *U.S. Public Health Services: Improving minority health statistics.* Washington, DC: Public Health Service. Office of Minority Health.

U.S. Department of Health and Human Services. (1997). *Health United States 1996-1997 and injury chartbook.* Hyattsville, MD: Centers for Disease Control and Prevention, National Center for Health Statistics.

U.S. Department of Health and Human Service Office of Minority Health. (1999). *Assuring cultural competence in health care: Recommendations for national standards and an outcomes-focused research agenda.* Rockville, MD: Author.

Utley, E.R. (1974). *A comparison of the values held by Black employees and white management in five state hospitals in Ohio.* Master's Thesis. Columbus, OH: Ohio State University.

van Manen, M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy.* New York: State University of New York

Press.

Vazquez, L. A. (1997). A systemic multicultural curriculum model: the pedagogical process. In D.B. Pope-Davis & L.K. Coleman (Eds.). *Multiculturalcounseling competencies: Assessment, education and training, and supervision.* Thousand Oaks, CA: SAGE Publications. 159-183.

Wade, P. & Bernstein, B.L. (1991). Cultural sensitivity training and counselor's race: Effects on Black female clients' perceptions and attrition. *Journal of Counseling Psychology, 38*(1), 9-15.

Weaver, H.N. (1999). Indigenous people and the social work profession: Defining culturally competent services. *Social Work, 44*(3),217-225).

Welfel, B.A. (1982). How students make judgments: Do educational level and academic majors make a difference? *Journal of College Student Personnel, 23,* 490-497.

Wells, S.A. (1991). Clinical considerations in treating minority women who are disabled. *Occupational Therapy Practice, 2*(4), 13-22. Aspen Publishers, Inc.

Wells, S.A. (1996). *Cultural competence: Preparing for the next millennium.* Workshop Presentation. College of Occupational Therapists 20th Annual Conference, University of Leeds.

Wells, S.A & Black, R.M. (2000). *Cultural competency for health professionals.* Bethesda, MD:American Occupational Therapy Association.

Wells, S.A. & Whiting, F. (1998). A celebration of diversity: Reviewing AOTA's

progress toward creating a more diverse profession. *OT Practice*, March, 31-34.

Westbrook, M. T., Skropeta, C.M., & Legge, V. (1991). Ethnic clients in diversional therapy programs. *Australian Occupational Therapy Journal, 38*(1), 251-258.

Whiteford, G.E. & Wilcock, A.A. (December 2000). Cultural relativism: Occupation and independence reconsidered. *Canadian Journal of Occupational Therapy*. (pp.324- 336).

Wilson, J.K. (1998). *The myth of political correctness*. Durham and London: Duke University Press.

Wiseman, R.L., Hammer, M.R., & Nishida, H. (1989). Predictors of intercultural communication competence. *International Journal of Intercultural Relations, 13,* 349-370.

Wittman, P. & Velde, B.P. (2002). The Issue Is. Attaining cultural competence, critical thinking, and intellectual development: A challenge for occupational therapists. *American Journal of Occupational Therapy, 56*(4), 454-456.

Zeller, C. (1995). Cultural vignettes: A multicultural educational teaching strategy. *Nurse Educator, 20*(2), 8-9.

APPENDIX A

Dissertation Prospectus
&
Consent Form

Dissertation Prospectus

Investigator: Roxie M. Black

STATEMENT OF THE ANALYTIC TOPIC

The Research Question:

The purpose of this study is to examine how occupational therapy students "voice" their understanding, definition, and interpretation of the concepts of cultural competence and culturally competent care during the last semester of the academic portion of their education. The intent is to listen carefully to the specific language and words used by these students in an effort to understand the essential nature of cultural competency as understood by the participants during their educational experience.

Definition of Terms:

Occupational therapy students will include matriculated students enrolled full time in an entry level accredited occupational therapy education program. Because the majority of occupational therapists are white and female , I would expect that the majority of participants will be white female students. It is possible, however, that there will be white men as well as men and women of color in the study.

The term *voice* is defined as "the power of speaking or the right of expression" (Merriam-Webster 1995, p.586). It means speaking and being heard. Gilligan (1993) defines *voice* as follows:

> . . . I mean something like what people mean when they speak of the core of the self. Voice is natural and also cultural. It is composed of breath and sound, works, rhythm, and language. And voice is a powerful psychological instrument and channel, connecting inner and outer worlds. Speaking and listening are a form of psychic breathing. This ongoing relational exchange among people is mediated through language and culture, diversity and plurality. For these reasons, voice is a new key for understanding the psychological, social, and cultural order - a litmus test of relationships and a measure of psychological health. (p. xvi).

Listening carefully to the words and language participants use as they describe their experiences is an intentional and important aspect of this study. Many other examinations of cultural competence in the literature use self-report surveys in which participants respond to language (about cultural competence) chosen by someone else (the authors of the surveys). Because voice reflects one's cultural position in society (Gilligan 1993), and because the focus of the study is on cultural competence, this researcher believes that it is important to examine the

manner in which the respondents voice their experiences with and understanding of the phenomenon of cultural competence.

Culture is defined as the sum total of a way of living, including values, beliefs, standards, linguistic expression, patterns of thinking, behavioral norms, and styles of communication that influence the behavior(s) of a group of people that is transmitted from generation to generation (Wells & Black, 2000). This definition refers to a broad range of cultural groups including subgroups related to race, ethnicity, age, gender, sexual orientation, class, and ability.

In the occupational therapy literature, *cultural competence* has been defined as people "moved from being culturally unaware to being sensitive to their cultural issues and how their values and biases affect racially different patients/clients" (Pope-Davies, Prieto, Whitaker, & Pope-Davies 1993, p. 839). Within counseling psychology Sue (1998, p. 440) states that cultural competency "is the belief that people should not only appreciate and recognize other cultural groups but also be able to effectively work with them." This definition is supported by that of the Cross Cultural Health Care Center(1995) which reports that "cultural and linguistic competence suggests an ability by health care providers and health care organizations to understand and respond effectively to the cultural and linguistic needs brought by patients to the health care encounter."

The definition most often quoted in the literature, however, comes from Cross, Bazron, Dennis and Issacs in a monograph entitled, *Towards a Culturally Competent System of Care, Vol 1* (1989). Cross et al define cultural competence as a "set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations." This definition may be quoted more often because it moves the concept of cultural competency beyond individuals and into organizations and communities. It supports the examination of the climate of an organization and the policies that enhance or diminish a climate of competency. This definition takes a much broader view of the concept, which in turn suggests that research related to cultural competency can also be directed to broader fields rather than to just individuals.

Culturally competent care is the process of actively developing and practicing appropriate, relevant, and sensitive strategies and skills in interacting with culturally different persons (AOTA Multicultural Task Force, 1995). It incorporates three major characteristics from the care provider. These include self-awareness,

knowledge (not only of other groups but also of the issues of power, privilege and oppression), and the skills to work effectively within cross-cultural interactions (Kavanagh & Kennedy 1992; Lynch & Hanson 1998; Pedersen & Ivey 1993; Wells & Black 2000).

HOW THE RESEARCH QUESTION WILL BE ADDRESSED

Research Design:

Because of the nature of the research questions and the intent to examine the meaning of student's understanding and experience of cultural competence, a phenomenological qualitative inquiry approach will be employed. " A phenomenological study describes the meaning of the ***lived experiences*** for several individuals about a concept or ***the phenomenon*** " (Creswell, 1998, p. 51). Moustakas (1994) states that the research question must have both social meaning and personal significance. The topic of this study meets both of these criteria. As an educator who has devoted significant study to the concept of cultural competence, it is important to me to understand how students perceive of this concept. Additionally, as the occupational therapy profession continues to examine cultural competence, a study of students' perceptions and meaning of the concept will be significant.

Methodology:

Participants

Up to twelve occupational therapy students who are in their last year of academic study in an urban University in the Northeast will be recruited to participate in the study. The university will be selected based on required multicultural content in its curriculum and its proximity to an urban area. The multicultural content must include minimally the aspects of culturally competent care identified in the literature as "self-awareness" and "knowledge" (Pedersen & Ivey, 1993; Wells & Black, 2000).The participants will be selected as a "Criterion Sample" (Creswell, 1998) as necessary to match the research design. In phenomenological inquiry participants must have experience with the phenomena being studied.(Moustakas, 1994) In this case, the students must have had classroom content which helps develop cultural competence. Participants will be apprised in a cover letter that the study will include a minimum of one in-depth interviews.

Data Collection

One in-depth interview will be done with each student during the last semester of her academic program. The purpose of these interviews is to evaluate

each student's experience and understanding of cultural competence and culturally competent care.

Additionally, participants will be asked to fill out a short questionnaire that will gather demographic data such as age, gender, ethnicity, and experience with diverse groups of people. This data will provide pertinent personal information that may not be gleaned from the interviews. Reflective field notes will be taken following each interview. These notes will describe the process of the interview and any additional data observed.

Method of Analysis

Phenomenological research design follows a clear sequence of analytical steps. The first step of the process is the *epoch* where "the everyday understandings, judgments and knowings [of the researcher] are set aside, and phenomena are revisited, freshly, naively in a wide open sense" (Moustakas 1994, p.33). It is under these conditions that the interview is conducted. Synthesizing the information from Moustakas (1994) and Creswell (1998), the steps of analysis include:

1. *Horizonalization* - examination of the interview transcripts and listing of the significant non repetitive and non overlapping statements of how each participant experiences the phenomena.
2. Relate and cluster these statements into "*meaning units" or "themes*". Then synthesize these "meaning units" into a "*textural description*" of the experience - what happened - including verbatim examples.
3. The researcher then constructs a *structural description* of each transcript that describes how the participant experienced what she did.
4. *Composite textual and structural descriptions* are then developed from the data.
5. The final step of phenomenological analysis is the presentation of a narration of the "essence" of the experience, which is a synthesis of the information found in step #4.

MOTIVATION AND ANTICIPATED CONTRIBUTION

In the health professions, and in occupational therapy in particular, it is vitally important to be client centered in approach, to understand the values, beliefs and interests of the client in order, not only to develop rapport, but also to fully engage that person in therapeutic interventions that are meaningful to them and, therefore, beneficial and effective. A person's values, beliefs and interests are determined by one's sociocultural background, as are the occupations or activities that are meaningful and in which one engages. One's cultural beliefs also determine how a

person defines health and wellness, how she responds to the sick role, and how she interacts with health care personnel.

Although the changing demography of the United States has resulted in an increasingly diverse patient population, the occupational therapy work force continues to be comprised of predominantly white women. For therapists to work effectively with the changing population, they must increase their cultural competence in order to deliver culturally competent care.

Cultural competence is a fairly new concept in occupational therapy although other professions, especially counseling psychology, nursing, and social work, have addressed these issues for years. It has been only since 1991 that the educational standards for occupational therapy have included statements about diversity (Educational Standards, 1991). Since that time there have been only a few publications on the topic of cultural competence (Khamisha, 1997; MacDonald, 1998; Pope-Davis, Prieto, Whitaker & Pope-Davis, 1993; Wells & Black, 2000), and very little research. Although there are educational standards that require inclusion of diversity issues in occupational therapy curricula, there have been no guidelines suggesting ways to teach for cultural competence and no assessments have been developed to evaluate the effectiveness of curricular offerings.

Research on the effectiveness of cultural competence has abounded in other professions, however. There have been studies that examine various models for, teaching cultural competence (Manoleas, 1994; Ronnau, 1994; Nakanishi & Rittner 1992; Lenburg, 1995; Pope-Davis, Eliason, & Ottavi, 1994; Napholz, 1999; St.Clair & McKenry, 1999). Several studies examined the various characteristics of cultural competency (Cui & Awa, 1992; Dinges & Baldwin, 1996; Martin, 1987; Wiseman, Hammer, & Nishida, 1999). Additionally, there were also studies reported in the literature that examined client perceptions of culturally competent providers (Gim, Atkinson, & Kim, 1991; Rogers, 1998; Wade & Bernstein, 1991).

What became apparent to me as I reviewed this research was that the majority of the studies were empirically based, incorporating self-report survey instruments to collect data on cultural competence. These tools were used because they lent themselves to quantitative analysis. Most of the self-report scales used in these studies have multiple questions that attempt to identify and assess the attributes of cultural competence.

My biggest concern with self-report surveys is that they do not allow the respondent to answer the questions in their own voice and words, because that type of response is too difficult to quantify. Therefore, these so called "self-report" surveys do not actually seek a respondent's personal thoughts, ideas and experiences about cultural competency. Rather, they ask a participant to respond to the thoughts and ideas of the author(s) of the survey. I believe this is a significant

deficit in the literature and research on cultural competence.

Therefore, I believe that the research study outlined in this prospectus will make a significant contribution to the developing literature in the field of occupational therapy. Examining the perceptions and experiences of the phenomena of cultural competence and culturally competent care by students, and reporting the essence of that experience will provide occupational therapy educators and practitioners with important information to guide curriculum and practice. Additionally, examining the voices and perceptions of students as they discuss their experience with cultural competency will provide an alternative way to examine this phenomena that has not yet been reported in the literature of any discipline.

Consent Form

To: Potential Research Participants:

This is an invitation for you to participate in my dissertation research study," The Meaning of Cultural Competence and Culturally Competent Care in Occupational Therapy Students". This has been an interest of mine for years, and will provide important information to the growing body of literature related to multiculturalism and occupational therapy.

The purpose of my study is to examine how occupational therapy students talk about and understand the phenomena of cultural competence and culturally competent care. Data collection for the pilot will entail two interviews of approximately 1 to 1 1/2 hours each. The first will occur this spring while you are still taking courses, and the second one during the latter part of your last level II fieldwork experience in the fall. The interviews will take place in a setting convenient for you. They will be recorded and then transcribed in order to precisely understand your words and meanings. You will also be asked to fill out a brief and simple questionnaire that will provide me with demographic information about you and your academic experiences.

Confidentiality will be maintained at all times. Your name will not be associated with the findings in any way, and your identity as a participant will be known only to me. All data (audio tapes and questionnaires) will be stored in a secure file in the office of my residence, and will be destroyed following the completion of my dissertation paper. There are no known risks and/or discomforts associated with this research. If you choose to participate, you would be free to withdraw from the study at any time without penalty.

Your participation in this study will be of great benefit to the occupational therapy academic community as we explore and report on the meaning of cultural competence for OT students. Further, it will give you first-hand experience as a participant in the research process. I am excited to work with you on this project, and appreciate your willingness to help me with my study. Please sign your consent with full knowledge of the nature and purpose of the procedures. A copy of this consent form will be given to you to keep.

Signature of Participant Date

Telephone Number Email Address

If you have any comments or questions about this research study, please contact:

Roxie M. Black, MS, OTR/L Director, MOT Program

Tel. (w) (207)753-6515; (h) (207)829-3542; email (w) rblack@usm.maine.edu (h) rblack@maine.rr.com

APPENDIX B

Cover Letter
&
Interview Protocol

Interview Protocol

Project: The Meaning of Cultural Competence

Time of
Interview_____
Date_____Place_____
Interviewer_____
Interviewee_____

Questions:

1. Describe an experience that you have had that exemplifies/demonstrates cultural competence

2. What was it like to have this experience? Explore: what did it feel like?

3. Describe an experience you've had that demonstrates the opposite of cultural competence.

4. How does this experience differ from the first you described?

5. In a practice setting, describe a time when you've either been part of, or have observed culturally competent care.

6. What was it about that experience that made you realize it was ccc?

7. Describe a fantasy about the best culturally competent interaction there could be. What would it look like and what would it feel like?

8. What about this interaction makes it the best?

Post Interview Observations

About the Interviewee:

About the Setting:

About the Process:

Phenomenological Interviewing
Exploratory Comments

How did it happen?
How did you talk about it?
Who said what?
How did you feel about that?
In what way?
Can you give me an example?
What was it like?
What did it feel like?
Tell me a story about it.

Tips for Interviewing

LISTEN
Don't be too directive
Don't overstructure
Avoid why. Aske how or what questions
Don't ask opinions or ideas - but details of the experience

Cover Letter

Roxie M. Black, MS, OTR/L
Director, MOT Program
University of Southern Maine
Lewiston/Auburn College
51 Westminster Street
Lewiston, Maine 04240

March 2, 2001

Dear Occupational Therapy Student:

You may recognize from my name that I have recently coauthored a book with Shirley Wells entitled Cultural Competency for Health Professionals. Despite the information in our book, however, there is still much more to discover about this topic.

I am a doctoral student at Lesley University, Cambridge, Massachusetts. I am planning a qualitative study for my dissertation research that focuses on the meaning of cultural competency for occupational therapy students. I am currently developing my study sample by inviting students from Tufts University, Boston University, and the University of New England to participate in my research.

I need students who are in their last year of study prior to completing their two level two fieldwork experiences, and who are willing to participate in two interviews that I would conduct. One interview would take place in March or April of this spring, and the second would occur in the latter half of your second fieldwork experience in the fall. The research participant must be willing to engage in both interviews.

It would be of great help to me, and would be extremely beneficial to the Occupational Therapy profession, if you are willing to participate in the study. Please

fill out and sign the enclosed consent form and return to me at the above address. Or you may email me with your information, and I will contact you to make arrangements for the first interview. If I receive significantly more offers of participation than I need for the study, participants will be chosen on a random basis.

Thank you again for your interest. I look forward to hearing from you.

Sincerely,

Roxie M. Black, MS, OTR/L

P.S. **Please respond by March 16, 2001.**

APPENDIX C

Participant Questionnaire

Research Study
"The Meaning of Cultural Competence
and Culturally Competent Care for Occupational Therapy Students"

Primary Investigator: Roxie M. Black

PARTICIPANT QUESTIONNAIRE

Name (Optional)_____ Participant Code #_____

College/University_____

Age_____Gender_____Race/Ethnicity_____

Tel. #
(daytime)_____(night)_____

email
address_____

Level II Fieldwork
Site_____

Address_____Dates_____

2nd Level II
Site_____

Address_____Dates_____

Definition:

Culture: The sum total of a way of living, including values, beliefs, standards, linguistic expression, patterns of thinking, behavioral norms, and styles of communication that influence the behavior(s) of a group of people. This definition refers to a broad range of cultural groups and subgroups related to race, ethnicity, age, gender, sexual orientation, class, and ability

1. Have you spent time with people who are culturally different from yourself?
Y___N___

2. In what capacity have you been with diverse people?
Socially_____In School_____ Family _____
at Work_____

Please Explain:

3. At what level have you known diverse people?

I don't really know anyone who is different from me._____

As acquaintance(s)_____As friend(s)_____

As family member(s)_____Partner/Spouse_____

4. Have your experiences with diverse people been

Generally positive_____Sometimes positive_____

Neutral_____ Sometimes negative_____

Generally negative_____

Please Explain:

5. Have you lived in a foreign country? Yes____No_____

Where_____For How Long_____

6. Have you studied about multiculturalism/diversity in college? Yes___No____

7. In what ways have you studied? (Check all that apply.)

Specific courses_____Modules within a course_____

Individual lecture(s)_____ Guest speakers_____

Infusion throughout many courses_____Field Visits_____

Other (please describe):

3937-38